Office of Law Enforcement Support

Semiannual Report

January 1, 2025 – June 30, 2025

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 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, 2025.

In this report, the OLES provides details on 604 reported incidents and the results of completed investigations and monitored cases.

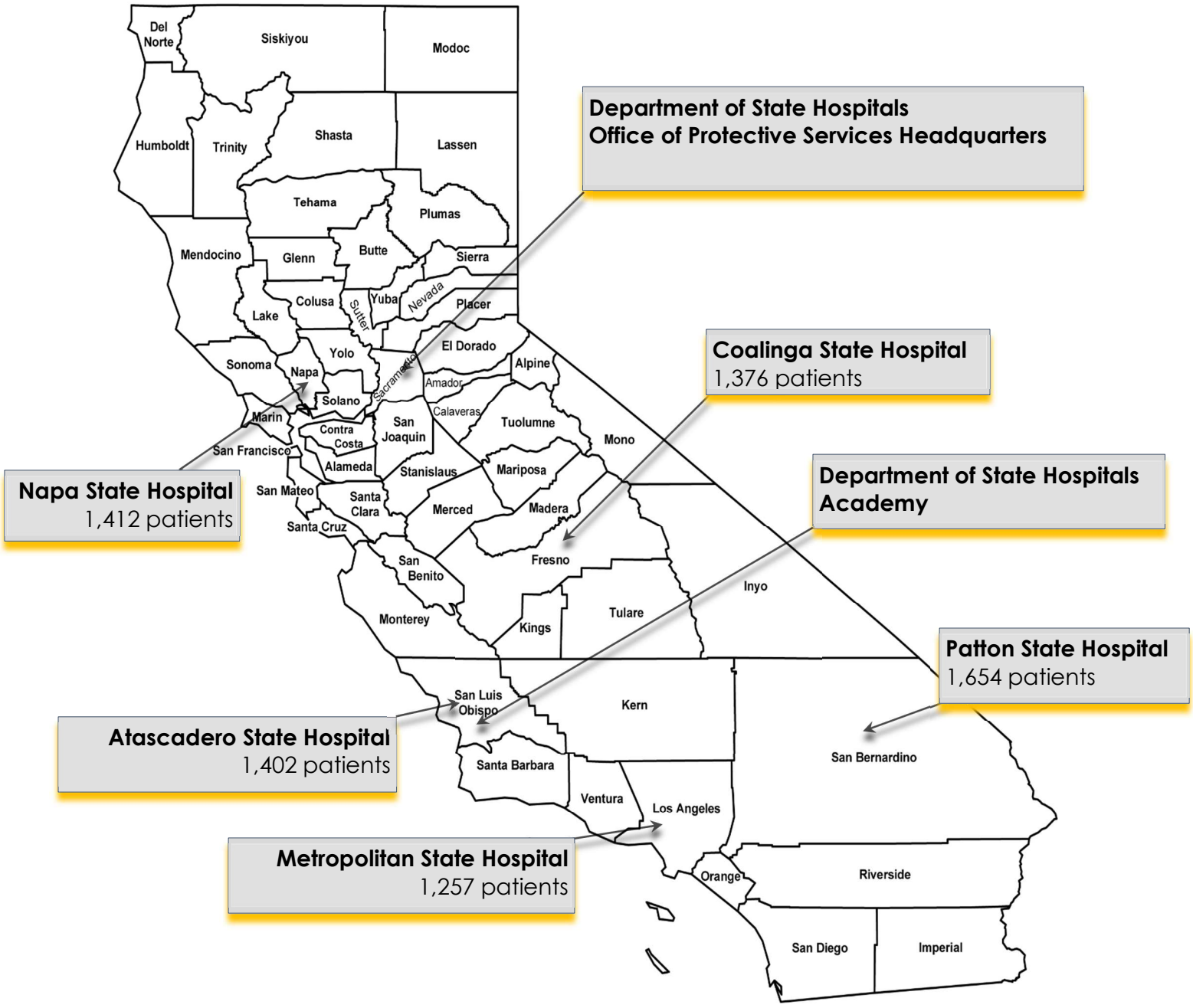
OLES provides updates on previous monitored issues regarding the use of the department's early intervention system, use of force reporting and documentation, firearms, and ongoing deficiencies in mandated reporting as required by Welfare and Institutions Code section 15630, et.al.

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/.

Christine Allen
Director
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, 2025, and were provided by the department.



Total Patients Served by Facility January 1 through June 30, 2025

DSH Facility	Total Number of Patients
Atascadero	1,402
Coalinga	1,376
Metropolitan	1,257
Napa	1,412
Patton	1,654
Total	7,101

The total number of patients served by DSH from January 1 through June 30, 2025, decreased 3.64 percent, from 7,369 during the prior reporting period to 7,101 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.

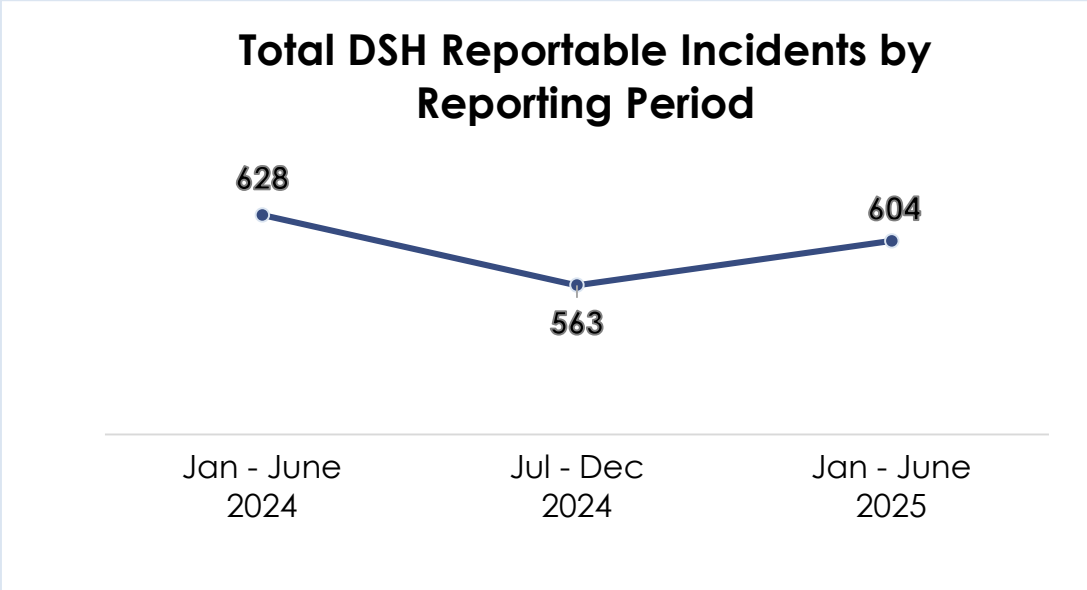
The following table provides the commitment type of patients served during the reporting period.

Commitment Type	Atascadero	Coalinga	Metropolitan	Napa	Patton
PC 1370 IST	332	0	1,001	722	686
PC 1026 NGI	296	<11	***	448	478
PC 2962/2964a OMD	401	0	0	0	87
PC 2972 OMD	***	285	<11	***	212
WIC 6316 MDSO	0	<11	0	<11	<11
PC 2684 CDCR	210	***	0	0	***
WIC 6602/6604 SVP	0	984	0	0	0
WIC 5358 LPS	***	<11	237	204	157

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, 2025, the Office of Law Enforcement Support (OLES) received and processed 604 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 an increase of 41 incident reports compared to the prior reporting period which had 563 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.

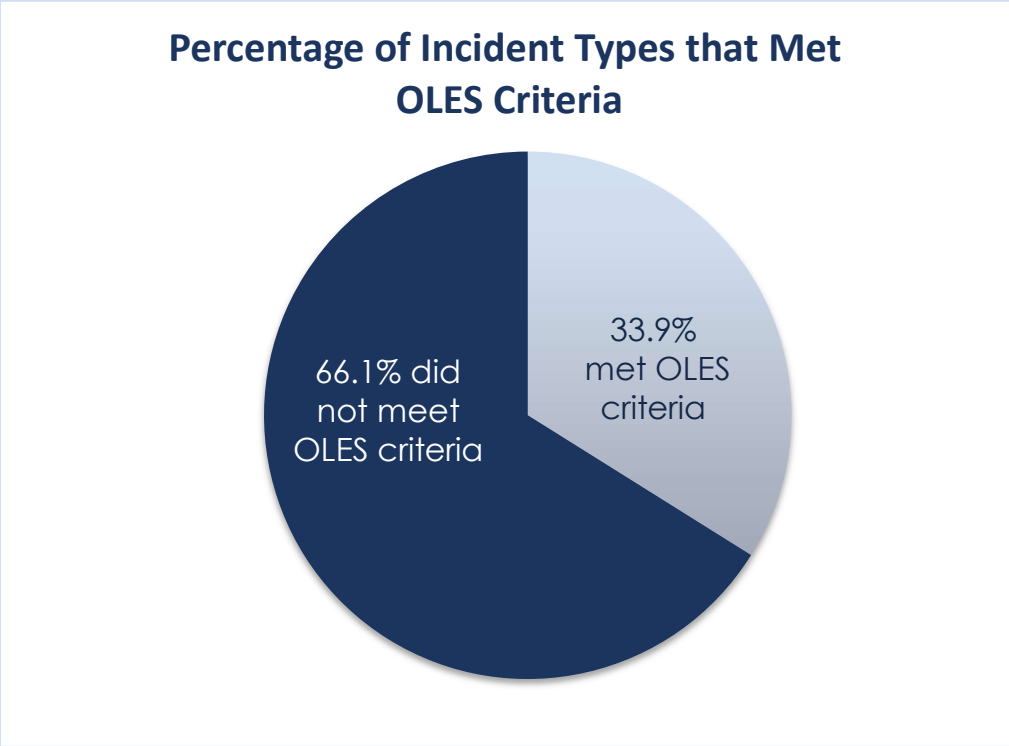
Incident Types Meeting OLES Criteria

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 OLES has determined meets OLES criteria for investigation, monitoring, or consideration for research as a potential departmental systemic issue. Out of the 604 reported incidents, OLES identified ten incidents with two or more incident types. The DSH reported a total of 613 incident types during this reporting period. Two hundred and eight, or 33.9 percent of the 613 incident types reported by DSH met OLES criteria.



Most Frequent Incident Types

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

Allegations of abuse were the most reported incident type, with 98 allegations reported, compared to 101 in the prior reporting period. Allegations of abuse accounted for 15.9 percent of all reported incident types by DSH.

Allegations of sexual assault were the second most reported incident type, with 83 incidents reported, compared to 79 in the prior reporting period.

Law enforcement use of force was the third 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 82 reports of use of force, which accounted for 13.4 percent of all reported incident types by DSH. Five of the 83 use of force reports included an allegation of excessive force, which are included in the Abuse and Misconduct totals and were assigned an OLES investigation.

For reporting purposes, OLES' reporting guidelines list 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.

Patient Deaths

The number of patient deaths decreased 2.9 percent, from 34 deaths to 33 deaths during this reporting period. Three of the reported death incident types met OLES criteria for monitoring. Eighteen of the 33 patient deaths were expected due to existing medical conditions. Fifteen 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 Coalinga State Hospital (CSH) with 19 deaths and Metropolitan State Hospital (MSH) with 7 deaths.

Patient Arrests

OLES works collaboratively with DSH to ensure patients receive the best possible treatment and care at the local jurisdiction holding facilities. OLES also reviews each patient arrest to safeguard patient rights and make certain there is strict compliance with 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 nine patient arrests, which were two more arrests compared to the prior reporting period. The patients were arrested for violations of the statutes listed in the following table. Five patients were arrested at CSH, three patients at MSH, 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 245 (a)(4)	Assault with battery
Penal Code section 243. (e)(1)	Domestic 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
Penal Code section 187(a)	Attempted murder

Results of Completed OLES Investigations of 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 15 investigations that OLES completed during this reporting period. As of June 30, 2025, there were approximately 742 DSH sworn staff.

OLES submitted 12 out of 12 completed administrative investigations to the hiring authorities at the facilities for disposition and monitored the disposition process in 11 of those cases. 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 conducted three criminal investigations; none of which were referred to the district attorney's office. OLES provides the department with summaries of the reviews and decisions of all criminal investigations in which OLES determined there was a lack of probable cause.

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 67 monitored administrative cases and 65 monitored criminal cases that, by June 30, 2025, 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-two pre-disciplinary administrative cases had sustained allegations. Three criminal investigations resulted in referrals to prosecuting agencies.

OLES monitored 132 pre-disciplinary phase cases; 123 of the pre-disciplinary phase cases are listed in Appendix B and 10 are listed in Appendix C. OLES rated 11 of the 123 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 investigations.

OLES monitored the disciplinary actions, *Skelly* hearings, settlements and State Personnel Board proceedings in 10 administrative cases listed in Appendix C. Four of the 22 disciplinary phase cases were rated insufficient due to a delay in serving a disciplinary action, failure to consult with OLES, and improperly conducted *Skelly* hearings, among other things.

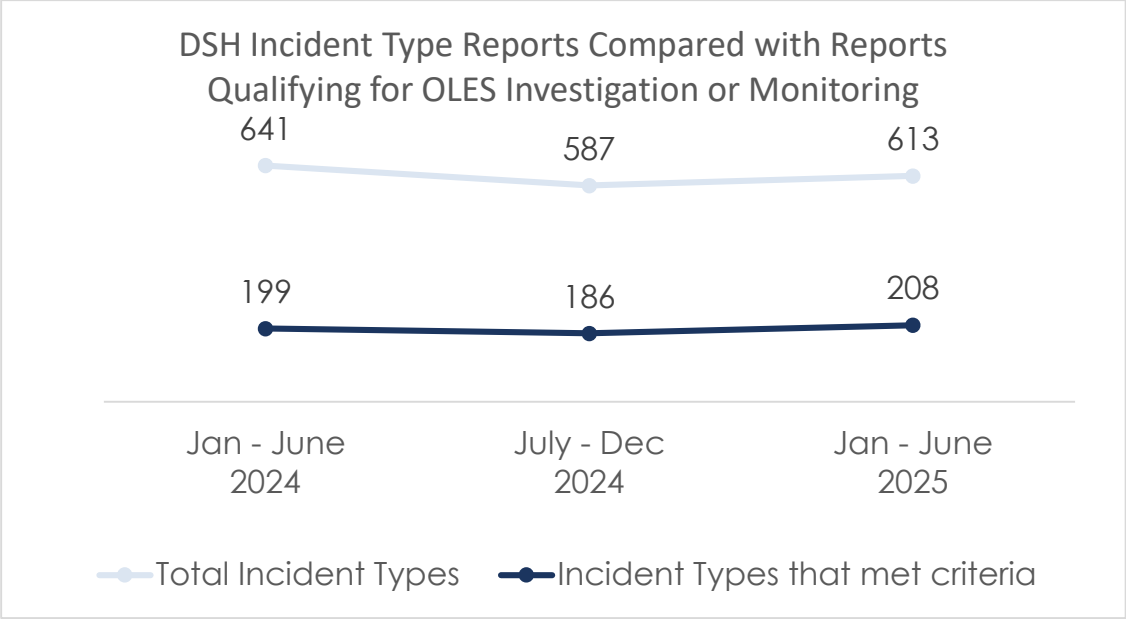
[3] Welfare and Institutions Code sections 4023, 4023.6, and 4427.5. (See Appendix D).

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, most incident reports came from the facilities.

Increase in Reported Incident Types

The number of DSH incidents reported to OLES from January 1 through June 30, 2025, increased 7 percent, from 587 during the prior reporting period to 613 in this reporting period. From the 604 reported incidents, OLES identified 613 incident types, as 10 of the incidents featured two or more incident types. Two hundred and eight of the 613 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 allegations of abuse, sexual assault, and use of force by law enforcement then broken bone (unknown origin). These four incident type categories accounted for 334 or 54.5 percent of all incident types reported by DSH. Of the 334 incident types, 146 met criteria for OLES to investigate or monitor.

The DSH's most frequent report to OLES was allegations of abuse with 98 reports. The number of abuse allegations that met criteria for investigation, monitoring or consideration of a potential systemic issue in this period was 95. The 98 reports of abuse accounted for 16 percent of the reported incident types.

Allegations of sexual assault were the second most frequently reported incident type by DSH, with 83 incidents reported. Allegations of sexual assault accounted for 13.5 percent of all incident types reported. Of the 83 sexual assault allegations reported in this period, 45 allegations or 54 percent qualified for investigation or monitoring.

The DSH's third most frequent report to OLES was use of force by law enforcement. The 82 reports of use of force accounted for 13.4 percent of the reported incident types, and down 10.9 percent from the last period's 92 reports. This is the eighth full reporting period of OLES requiring the department to report all use of force by law enforcement.

Allegations of broken bones of unknown origin were the fourth most frequently reported incident type by DSH, with 71 incidents reported. The 71 reports of broken bones of unknown origin accounted for 11.6 percent of the reported incident types.

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

Most Frequent Incident Types January 1 through June 30, 2025

Incident Type Category	Prior Period Incident Type Total July 1 through December 31, 2024	Current Period Incident Type Total	Percent Change from Previous Period	Current Period Number Meeting OLES Criteria
Abuse	101	98	-3%	95
Sexual Assault [2]	79	83	+5.1%	45
OPS Use of Force [1]	92	82	-10.9%	0
Broken Bone (Unknown Origin)	52	71	+36.5%	6

[1] Five 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.
[2] 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. Numbers in these columns are unadjusted and provided as they were previously published.

Incident Categories	Prior Period January 1 - June 30, 2024 (Reported)	Prior Period January 1 - June 30, 2024 (Meets Criteria)	Prior Period July 1 - December 31, 2024 (Reported)	Prior Period July 1 - December 31, 2024 (Meets Criteria)	Current Period January 1 - June 30, 2025 (Reported)	Current Period January 1 - June 30, 2025 (Meets Criteria)
Abuse	90	85	101	98	98	95
Attack-on-Staff [1]	5	0	6	0	1	0
AWOL	4	0	5	0	1	0
Broken Bone (Known Origin)	39	1	24	0	27	0
Broken Bone (Unknown Origin)	63	22	52	5	71	6
Burn	8	1	3	0	5	0
Child Sexual Abuse Material	5	0	4	0	1	0
Contraband (CCR Title 9 section 4350) [2]	N/A	N/A	1	0	2	0
Contraband Phones [2]	N/A	N/A	2	0	6	0
Death	38	15	34	6	33	3
Drugs [3]	25	2	19	0	35	1
Genital Injury (Known Origin)	6	0	9	0	10	0
Genital Injury (Unknown Origin)	8	1	5	0	10	5
Head/Neck Injury	46	2	47	1	51	0
Misconduct [4]	21	13	22	22	24	24
Neglect	14	11	17	13	17	13

Incident Categories	Prior Period January 1 - June 30, 2024 (Reported)	Prior Period January 1 - June 30, 2024 (Meets Criteria)	Prior Period July 1 - December 31, 2024 (Reported)	Prior Period July 1 - December 31, 2024 (Meets Criteria)	Current Period January 1 - June 30, 2025 (Reported)	Current Period January 1 - June 30, 2025 (Meets Criteria)
Non-patient assault/GBI on Patient	0	0	0	0	0	0
OPS Use of Force [5]	115	0	92	0	82	0
Over-Familiarity	15	15	10	10	14	14
Patient Arrest	8	0	7	0	9	0
Patient-on-Patient Assault/GBI	4	0	10	0	5	1
Pregnancy	0	0	0	0	0	0
Riot	0	0	0	0	0	0
Sexual Assault	77	31	79	31	83	45
Sexual Assault-Outside Jurisdiction [6]	49	0	37	0	23	0
Significant Interest [7]	0	0	1	0	2	0
Suicide (Attempted)	1	0	0	0	3	1
Total	641	199	587	186	613	208

1 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. This is the last reporting period OLES will report this incident type.

2 Beginning in the July 1, 2024, through December 31, 2024, reporting period, OLES established the reporting of California Code of Regulations, Title 9, Section 4350 contraband items. Contraband phones are reported separately.

3 Beginning in the July 1, 2021, through December 31, 2021, reporting period, 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.

4 The misconduct statistics include five allegations of excessive force by law enforcement, and two alleged sexual assaults. These incidents are included in the total count for all incident types reported.

5 The 82 use of force incidents were assigned a pending review. Five of the 82 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.
[6] Outside Jurisdiction sexual assault occurred outside the jurisdiction of DSH. This is the last reporting period OLES will report this incident type.
[7] Significant Interest is an incident that may draw media attention. There was alleged inappropriate messaging on social media by staff about a discharged patient, and alleged bomb threats by a patient.

Distribution of Incident Types

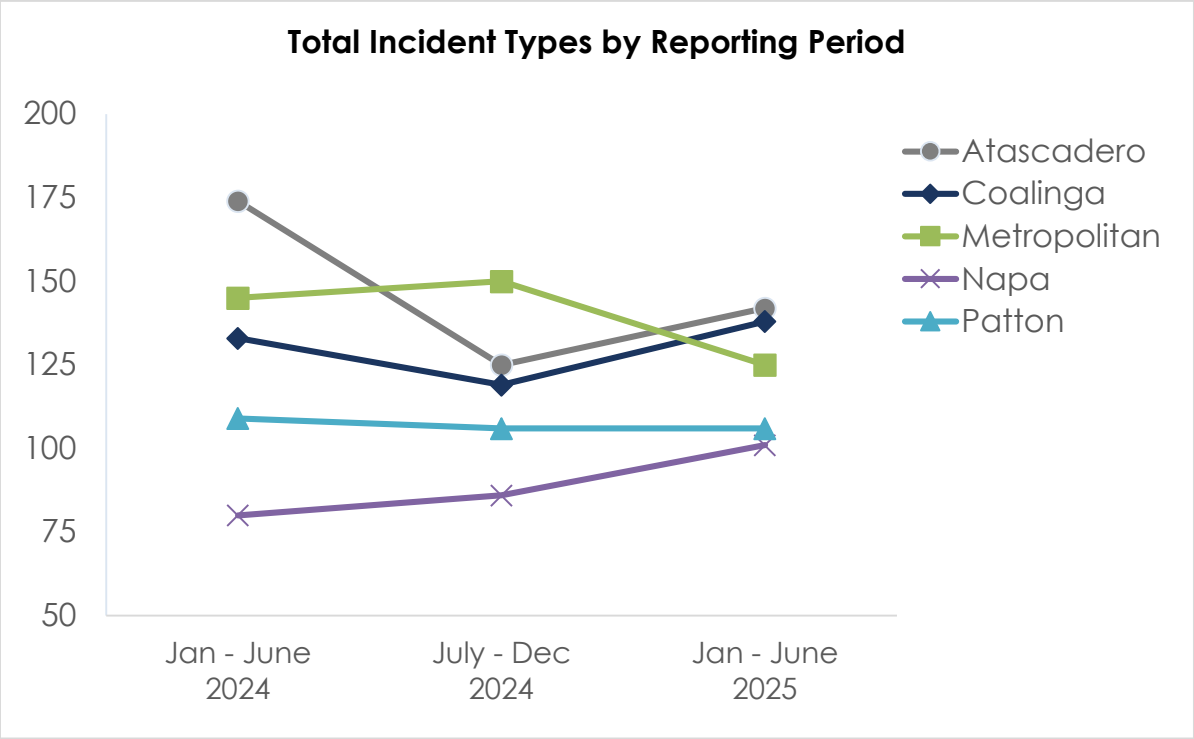
The following table compares the total number of patients served by facility to the total number of incident types reported during the reporting period.

DSH Population and Total Incident Types

DSH Facility	Number of Patients Served	Total Incident Types
Atascadero	1,402	142
Coalinga	1,376	138
Metropolitan	1,257	125
Napa	1,412	101
OPS Academy	0	1
Patton	1,654	106
Total	7,101	613

The department provided population served from January 1 through June 30, 2025.

The following chart depicts the total number of incident types for this reporting period and the prior two 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, 2025. The 83 alleged sexual assault incident types reported in this reporting period accounted for 13.5 percent of all reported incident types from DSH. Forty-five of the 83 reported incident types of alleged sexual assault, or 54.2 percent, met OLES criteria for investigation or monitoring. There were 23 reported incident types under the sexual assault outside jurisdiction category, none of which met OLES criteria for investigation or monitoring. This will be the last report of the category sexual assault outside jurisdiction.

Of the five DSH facilities, PSH (28), NSH (28) and ASH (10) 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 non-law enforcement staff on a patient, with 39 incident types or 47 percent of the 83 alleged sexual assault incident types. Patients assaulting other patient were the second most frequently reported, with a total of 34 incident types, or 41 percent of the alleged 83 sexual assault incident types. There were six allegations of sexual assault involving an unknown assailant on a patient. 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, 2025

Allegation Type	Total
Non-Law Enforcement Staff-on-Patient	39
Patient-on-Patient	34
Law Enforcement Staff-on-Patient	2
Unknown Person-on-Patient	8
Outside Jurisdiction [1]	23
Total	106

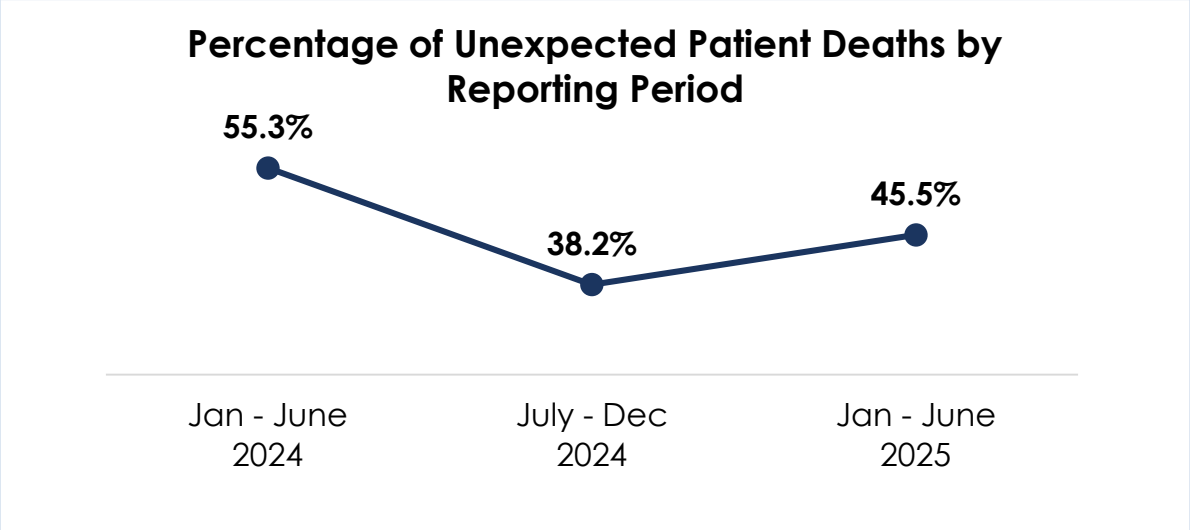
[1] Sexual assault outside jurisdiction is a patient report of an alleged sexual assault that occurred before the patient was in the care of the DSH. This is the last reporting period OLES will report this incident type.

Patient Deaths

The DSH reported 33 patient deaths to OLES during this reporting period. This number decreased 2.9 percent from the 34 patient deaths reported in the prior reporting period of July 1 through December 31, 2024.

Eighteen of the patient deaths were classified as expected primarily due to underlying health conditions, such as cardiac or respiratory issues and cancer. Fifteen deaths were classified as unexpected. Each unexpected patient death receives two levels of review within DSH, per department policy. OLES monitored three 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 among patients during this reporting period. There was one patient suicide while the patient was housed at a county jail.

Cause of Patient Deaths

Cause	Total
Cancer	3
Cardiac/Respiratory	25
Other	1
Pending Coroner's Report	3
Suicide	1
Total	33

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

Patient Deaths by Facility

DSH Facility	Total Number of Deaths
Atascadero	1
Coalinga	19
Metropolitan	7
Napa	3
Patton	3
Total	33

Reports of Head or Neck Injuries

The DSH reported 47 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 16 of the 47 reported head or neck injuries. One head or neck injury occurred due to an altercation with staff. This incident was monitored 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 five AWOL incident types. All patients were safely returned to their assigned areas; however, one patient was AWOL for five days.

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. This is the last reporting period OLES will report incident type sexual assault outside jurisdiction. 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
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.
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.
Drugs	Drug trafficking or smuggling.
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.

Incident	Description
Neglect	Any staff action or inaction that resulted in, or reasonably could have resulted in a patient death, or injury requiring treatment beyond first aid.
OPS Use of Force	Any Office of Protective Services staff member within DSH that uses any physical force, or physical technique, or an approved weapon to overcome resistance, gain control/compliance, or effect an arrest of a subject regardless if an allegation of excessive force or injury exists. Exceptions to this may include compliant handcuffing or searches of a subject as long as no resistance is offered by the subject to the officer or officers.
Over-Familiarity	Over-familiarity between staff and patients.
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.
Riot	As defined for OLES reporting purposes.
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).
Serious Crimes	The commission of serious crimes by patient(s) or staff.
Significant Interest	Any incident of significant interest to the public or any incident which may potentially draw media attention.
Suicide (Attempted)	A patient suicide attempt requiring treatment beyond first aid.

Timeliness of Notifications

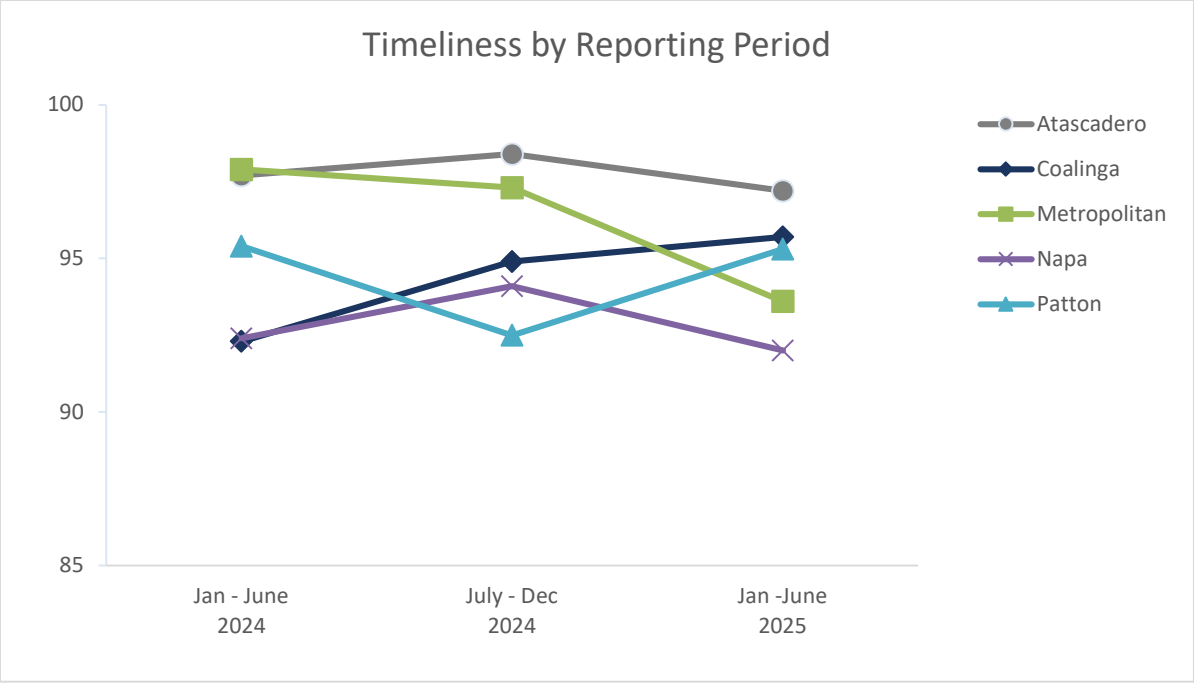
The DSH timely reported incident types 94.8 percent compared to the prior reporting period, which had 95.7 percent timely reports.

One of the 613 reported incident types were excluded from DSH's total incident type count when calculating timeliness. This incident was reported directly to OLES by a patient, family member of a patient, facility staff member or by an outside law enforcement agency. Of the 612 incident types evaluated for timeliness, 580 were reported timely and 32 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	142	138	4	97.2
Coalinga	138	132	6	95.7
Metropolitan	125	117	8	93.6
Napa	100	92	8	92.0
OPS Academy	1	0	1	0
Patton	106	101	5	95.3
Total	612	580	32	94.8

The following chart compares the percentage of timely facility 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, 2025, reporting period, 405 of the total 613 cases opened for DSH incident types that occurred within DSH's jurisdiction or 66.1 percent were assigned a pending review. OLES opened cases for 23 incidents that may have occurred while the patient was not housed within a DSH facility and assigned those cases a pending review. OLES opened 17 administrative investigations and 14 criminal investigations. OLES opened 144 monitored criminal cases and 33 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).

Incident Types Opened in the Current Reporting Period

OLES Case Assignments	January 1 – June 30, 2025	Percentage of Opened Cases
Pending Review	382	66.1%
Monitored, Criminal	144	23.5%
Monitored, Administrative	33	5.4%
Outside Jurisdiction [1]	23	3.8%
OLES Investigations, Criminal	14	2.3%
OLES Investigations, Administrative	17	2.8%
Totals	613	100%

[1] 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 15 investigations. 12 of the investigations were administrative. Three of the 15 investigations were criminal.

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 provides 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 12 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, 2025	Referred to Prosecuting agency	Referred to facility management
Administrative	12	N/A	12
Criminal	3	0	N/A
Total	15	0	12

OLES Monitored Cases

In this report OLES provides information on 132 completed monitored cases. 65 of the 132 cases were criminal cases, three of the 65 cases were referred to a district attorney's office.

There were 67 completed monitored pre-disciplinary administrative cases during this reporting period. Twenty-two of the 67 cases had sustained allegations; 45 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	3
Criminal-Not Referred	62
Total Criminal	65
Administrative-With Sustained Allegations	22
Administrative-Without Sustained Allegations	45
Total Administrative	67
Grand Total	132

Pre-Disciplinary Phase Cases

Of the 67 pre-disciplinary phase cases provided in Appendix B and C, OLES rated 11 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 22 administrative cases. Four cases were insufficient due to, among other things, untimeliness, failure to consult with OLES, delays in serving the disciplinary action, and an improperly conducted Skelly hearing. 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:

- **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.
- **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.
- **Upward Mobility**: Upon completion of the mandatory and essential courses, an employee may pursue additional interests in their law enforcement training.
- **Career Related**: 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, 2025.

DSH Facility	Percentage of Compliance
Atascadero	98.5%
Coalinga	96.1%
Metropolitan	94.6%
Napa	100%
Patton	91.1%

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. The Chief of OPS attends these meetings and if a hospital is missing, he contacts the hospital police chief to ensure representation from all DSH sites.

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 [1]	Adverse action taken [2]	No adverse action taken [3]	Direct adverse action taken [4]	Resigned/ retired pending adverse action [5]
Atascadero	31	3	18	9	1
Coalinga	46	0	18	28	0
Metropolitan	24	2	17	5	0
Napa	0	0	0	0	0
Patton	63	8	35	20	0
Total	164	13	88	62	1

1 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.

2 Adverse action taken refers to a Notice of Adverse Action being served to an employee after an investigation was completed. These numbers include rejecting employees during their probation periods.

3 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.

4 Direct adverse action taken refers to a Notice of Adverse Action being served to an employee without the completion of an investigation. These numbers include rejecting employees during their probation periods.

5 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 [1]	Referred to prosecuting agencies [2]	Not referred [3]	Rejected by prosecuting agencies [4]
Atascadero	31	0	31	0
Coalinga	16	3	13	1
Metropolitan	39	1	38	1
Napa	18	2	16	0
Patton	53	53	0	0
Total	157	59	98	2

1 Employee criminal cases include criminal investigations of any employee. Numbers are for investigations which were completed during the OLES reporting period and do not necessarily reflect when the crimes occurred.
2 Cases referred to prosecuting agencies are criminal cases where the investigations were completed and were then referred to an outside prosecuting entity.
3 Criminal cases not referred to prosecuting agencies due to a lack of probable cause.
4 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	3	1	0
Coalinga	0	0	0	0
Metropolitan	0	0	0	0
Napa	0	0	0	0
Patton	0	0	1	0
Total	0	3	2	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 [1]	Referred to prosecuting agencies [2]	Not referred [3]	Rejected by prosecuting agencies [4]
Atascadero	361	49	312	67
Coalinga	299	168	131	103
Metropolitan	193	21	172	13
Napa	14	2	12	4
Patton	90	64	26	14
Total	957	304	653	201

1 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.
2 Cases referred to prosecuting agencies are criminal cases where the investigations were completed and were then referred to outside prosecuting entities.
3 Criminal cases not referred to prosecuting agencies due to a lack of probable cause.
4 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 director 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.

Purchase of Off-Roster Firearms by Sworn Personnel

In the course of OLES' review of the recordkeeping of institutional firearms and crime/evidence firearms, it was discovered that some sworn personnel were purchasing off-roster firearms to carry off duty using DSH credentials, potentially in violation of California Penal Code section 32000, subdivision (b)(6)(F). This statute requires that DSH sworn personnel meet certain qualifications in order to purchase off-roster firearms. In order to address this concern, OLES recommended that DSH review and update its policies concerning off duty firearm qualification standards, rangemaster qualifications, qualification records, and off duty carry authorizations on identification cards to ensure consistency with the law.

In response to OLES' recommendations, The OPS formed an OPS Policy Revision Committee. This committee was composed of representatives from all five state hospitals and Sacramento OPS. The representatives were primarily range masters from each of the state hospital police departments. The committee concentrated on off-

duty firearms qualifications standards, rangemaster qualifications, armorer qualifications, qualification records, and firearm inspections. DSH legal was added to this committee to assist in a review of the applicable laws. After the committee meetings there were several meetings with the directorate, DSH Legal, and OLES. Additional information was added into the policy regarding California Penal Code Section 32000 stating the purchase of firearms pursuant to section 32000 is prohibited because DSH provides the service weapons to the investigators and officers appointed under California Penal Code 830.38 are not authorized to carry service weapons in the course and scope of their employment, unless serving as a rangemaster. The language on the DSH Law Enforcement Officer identification cards was also changed. A decision was made to bifurcate information regarding off-duty qualification into a separate policy to clearly define on and off duty qualifications and responsibilities. Both policies were published on September 15, 2025.

OLES will close this monitored issue.

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 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 effectively utilize Blue Team/IAPro. 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).

In subsequent reviews, OLES highlighted ongoing concerns about DSH's delays in promptly entering reportable incidents into Blue Team/IAPro while acknowledging DSH's commitment to improvement through additional training and updates to the procedure manual. OLES recommended that DSH immediately address reporting inaccuracies by implementing stricter protocols and ensuring timely data entry. Enhanced oversight through regular audits, accountability for leadership, and comprehensive employee training were also advised to improve compliance and accuracy in incident reporting.

In February 2025, DSH adopted a supervisor-centric model, with compliance verified through audits conducted by DSH-HQ. At the same time, the Office of Protective Services (OPS) delegated daily management of Blue Team/IAPro to local hospital administrators while retaining overall oversight of its use by hospital police departments. OPS Sacramento staff completed training from CI-Technologies to support manual updates, which are currently in process, and new training programs. Training for both

local administrators and supervisors has been completed.

In September 2025, OLES audited Blue Team/IAPro data submitted by DSH, for use-of-force incidents occurring at Atascadero State Hospital (ASH), January 1 through June 30, 2025. The review identified 133 total entries. Within the reporting period, ASH recorded 48 use-of-force incidents: 14 were recorded once, and 34 were recorded multiple times, resulting in 48 duplicate entries. The remaining 37 entries reflected incidents outside the reporting period.

During the same period, ASH reported 49 use-of-force incidents to OLES. Of the reported incidents, 48 were reflected in the Blue Team/IAPro data that DSH provided, indicating one incident was not entered in Blue Team/IAPro.

OLES will continue monitoring the department's use of Blue Team/IAPro.

Use of Force Reports, Reviews and Tracking at DSH

On July 15, 2021, OLES issued a monitored issue memorandum documenting concerns and recommendations regarding the use of force on patients at DSH facilities after reviewing 42 use of force packages submitted to OLES from August 3, 2020, to July 15, 2021. A use of force report documents an operational incident and does not necessarily indicate misconduct or excessive force by an officer.

On December 28, 2021, DSH acknowledged there were opportunities for improvement in its UOF review and reporting process. The DSH's Chief of Law Enforcement and an external law enforcement use of force expert reviewed DSH's policies and use of force reporting processes to identify opportunities to strengthen DSH's processes. By September 2023, an 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. After completing a use of force policy update in July 2024, DSH released it departmentwide for review and acknowledgment, advising statewide training on the updated policy was forthcoming. In August 2024, OLES and DSH executive and command staff previewed the use of force training video the DSH Academy staff produced, which would be disseminated to each facility to train the OPS staff.

In January 2025, DSH's Chief of Law Enforcement reported that all staff have completed the use of force training using the academy-produced video, marking the full implementation of the training component. This reinforces the department's commitment to ensuring staff are properly trained and prepared to apply the updated policy effectively.

On July 10, 2025, DSH provided OLES with 11 updated use-of-force forms for review, which together comprise the Use of Force Packet. The packet is designed to provide a comprehensive, transparent, and standardized record of any force used by OPS officers, ensuring accountability and compliance with state law and departmental policy. Its purpose is to capture the facts, evidence, and reasoning behind a force

incident in a manner that is complete, accurate, and unbiased, while enabling a multi-layered review process. This process evaluates not only the actions of officers but also the adequacy of supervisory oversight, the integrity of documentation, and adherence to established procedures.

At its core, the UOF packet contains incident reports written by officers that detail their roles, observations, and justification for the level of force applied. Supervisors then expand on this record through formal critiques, including patient interviews conducted by uninvolved OPS officers. These patient interviews must be video recorded when serious bodily injury or allegations of excessive force are involved, with refusals documented. The packet also includes photographs of injuries and pre-existing conditions, along with medical documentation following the incident.

The packet then moves through a deliberately structured successive level of review, with each level of leadership contributing oversight and verification. A sergeant initiates the supervisory review, which is followed by a lieutenant's evaluation and findings. The Chief of Police then scrutinizes the packet for completeness and compliance. From there, the Executive Director and, when appropriate, the Facility Executive Committee review the packet, with further independent oversight provided by OLES and the DSH Chief of Law Enforcement. Thus, the packet serves not merely as an administrative requirement but as a safeguard that preserves the integrity of the investigative process, protects the rights of patients and staff, and reinforces public trust.

Following the DSH submission, OLES reviewed the updated forms and on August 26, 2025, returned them to DSH with suggestions and recommendations for consideration. On September 11, 2025, DSH advised OLES that they intend to incorporate some of the suggestions but also wished to discuss some of the recommendations with possible alternatives.

OLES will continue to oversee the department's adherence to the use-of-force policy and its review process to ensure consistency, accountability, and continuous improvement.

Delayed Reporting by Other Mandated Reporters

In December 2021, the 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. The OLES reviewed reportable incidents it received notification on, noting OPS often made timely notification to OLES. However, Other Mandated Reporters did not always timely report these incidents to OPS or just completely failed to notify OPS altogether, despite specific statutory requirements to timely report such incidents to law enforcement. The delays ranged from several hours to several days after initial discovery, to no notification at all by these Other Mandated Reporters.

Such delays may have a negative impact on the investigation of these reportable incidents. Timely notification to appropriate law enforcement is critical, especially for alleged sexual assaults or other potential crimes of violence. When an allegation is

made of a recent sexual assault, time is of the essence. Valuable forensic evidence could be lost if a victim or suspect changes clothes, showers, brushes 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 mandated reporting posters and pocket guides for staff distribution which described reporting requirements for OPS to make notifications to OLES. OPS also met with level of care staff to review these 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.

In the reporting period of January 1, 2024, through June 30, 2024, the OLES identified eight incidents that were not timely reported by Mandated Reporters to OPS. During the reporting period of July 1, 2024, through December 31, 2024, the number increased to nine incidents of delayed reporting. Unfortunately, during the current reporting period of January 1, 2025, through June 30, 2025, the number has increased to 11. The 11 incidents are listed below:

Incident Type	Estimated Delayed Reporting to OPS
Broken bone (unknown origin)	Over 8 hours
Broken bone (unknown origin)	Over 4 hours
Sexual assault	Over 5 hours
Broken bone (unknown origin)	Over 3 hours
Physical Abuse	Over 5 hours
Physical Abuse	Over 5 hours
Genital Injury (unknown origin)	Over 22 hours
Physical abuse	Over 20 hours
Physical abuse	Almost 4 hours
Physical abuse	2.75 hours
Physical abuse	Over 5 hours

It should be further noted, OLES' original memorandum to DSH identified two types of required notification by Other Mandated Reporters:

1) Notification to OPS *and* outside law enforcement agency within two hours of discovery is required:

a. Whenever a mandated reporter (regardless of classification; LOC staff, social workers, law enforcement, etc.) has observed, has knowledge of, reasonably suspects, or has been told by a dependent adult (i.e., DSH patient) about alleged abuse that resulted in:
    i. Death
    ii. Sexual assault
    iii. Assault with a deadly weapon (by a non-patient)
    iv. Assault with force likely to cause great bodily injury
    v. Genital injury (including when cause of injury is undetermined), or
    vi. Broken bone (including when cause of injury is undetermined),
b. The mandated reporter shall notify both OPS *and* outside law enforcement agency within two hours of discovering the possible abuse.
c. These types of reportable incidents are similar to the OLES Priority 1 category of incidents requiring OPS notification to OLES within two hours of OPS discovery.

2) Notification to *either* OPS *or* outside law enforcement agency within two hours of discovery is required:
    a. Whenever a mandated reporter has observed, has knowledge of, reasonably suspects, or has been told by a dependent adult/DSH patient about any other allegation of abuse or neglect not resulting in any of the above criteria,
    b. The mandated reporter shall notify either OPS or an outside law enforcement agency within two hours of discovering the possible abuse or neglect.

OLES recommends that DSH provide additional statewide training to ensure all DSH mandated reporters are made aware of and comply with their obligations 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 would ensure accurate, thorough investigations are completed without delay or compromise. The OLES will continue to work with the department and monitor the department's progress on this issue.

In response to OLES' recommendations DSH has been actively working on finalizing a new Policy Directive for Mandated Reporting. OPS and SQI have worked collaboratively to incorporate all the various reporting requirements including reporting to outside law enforcement. DSH anticipates finalizing the policy by December 2025 and a statewide training will be required for all staff.

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, 2025. 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	03/05/2024
OLES Case Number	2024-00560-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	Two officers allegedly violated DSH policy by not recording the declination of recordings.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	06/11/2024
OLES Case Number	2024-00858-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement officer allegedly failed to file federal and state taxes.
Disposition	The investigation was completed by OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	07/23/2024
OLES Case Number	2024-01064-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement supervisor allegedly was dishonest and falsified records.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	08/18/2024
OLES Case Number	2024-01164-1A
Case Type	Investigative
Incident Types	1. Abuse - Physical
Incident Summary	A law enforcement officer allegedly used excessive force on a patient.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	
OLES Case Number	2024-01269-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	An officer allegedly destroyed official State documents.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	08/16/2024
OLES Case Number	2024-01308-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement officer allegedly made dishonest statements in a written statement to a supervisor.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	09/18/2024
OLES Case Number	2024-01322-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement officer allegedly failed to investigate abuse allegations made by a patient. Additionally, the officer allegedly failed to record the interview with the patient.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	09/17/2024
OLES Case Number	2024-01373-1A
Case Type	Investigative
Incident Types	1. Abuse - Physical
Incident Summary	An unidentified law enforcement officer allegedly inappropriately touched a patient's genitals during a mandatory search.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	10/24/2024
OLES Case Number	2024-01467-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement officer allegedly documented false information in an official report.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	11/05/2024
OLES Case Number	2024-01510-1A
Case Type	Investigative
Incident Types	1. Abuse - Physical
Incident Summary	Law enforcement officers allegedly assaulted a patient.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	11/27/2024
OLES Case Number	2024-01598-1C
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	An off-duty law enforcement officer allegedly fled from an outside law enforcement agency when they attempted to enforce a traffic stop on the officer's vehicle. The officer failed to report his contact with outside law enforcement to his supervisor.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	12/05/2024
OLES Case Number	2024-01609-2A
Case Type	Investigative
Incident Types	1. Use of Force Review
Incident Summary	A law enforcement officer allegedly used excessive force on a patient.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	12/28/2024
OLES Case Number	2025-00017-1A
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement supervisor allegedly falsified their timesheet.
Disposition	The investigation was completed by the OLES and submitted to the hiring authority for disposition.

Case Details	Description
Incident Date	01/13/2025
OLES Case Number	2025-00082-1C
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement officer allegedly used unnecessary force on a patient.
Disposition	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	01/28/2025
OLES Case Number	2025-00127-1C
Case Type	Investigative
Incident Types	1. Peace Officer Misconduct
Incident Summary	A law enforcement officer allegedly sexually assaulted and impregnated a patient.
Disposition	The 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.

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, 2025, 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	03/04/2023
OLES Case Number	2023-00342-2A
Case Type	Monitored
Incident Types	1. Genital Injury (Unknown Origin)
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	Unidentified staff members allegedly neglected a patient who developed severe pressure wounds requiring surgical intervention.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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 took 586 days to complete. The initial investigation was insufficient because it did not identify any potential staff subjects, nor did it include relevant policies and procedures. The hiring authority rejected the investigation and requested additional investigative steps be taken. The investigators assigned to the case did not consult with OLES other than to notify the monitor of one interview.
Pre-Disciplinary Assessment	1. Did the department appropriately determine the deadline for taking disciplinary action (statute of limitation date)? • No The investigator did not discuss/determine the statute of limitations. 2. Did the investigator adequately prepare for all aspects of the investigation? • No The investigator failed to identify and interview potential subjects. 3. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? • No The draft investigative report failed to identify potential subjects. 4. Was the final investigative report thorough and appropriately drafted? • No The final investigative report failed to identify potential subjects. 5. Was the investigation thorough and appropriately conducted? • No The investigation was not appropriately conducted because the investigator failed to identify and interview potential subjects and witnesses. Further, the patient was not interviewed. 6. If the hiring authority consulted with OLES concerning the sufficiency of the investigation and the investigative findings, was the hiring authority adequately prepared? • No The hiring authority was not fully informed about the

	procedural posture of the case and why the initial hiring authority had found the initial investigation insufficient. 7. Did the hiring authority properly deem the OPS investigation sufficient or insufficient? • No The hiring authority did not properly deem the OPS investigation sufficient. The investigative report listed the patient as the subject and no other subjects were identified. 8. Did the hiring authority who participated in the findings conference identify the appropriate subjects and factual allegations for each subject based on the evidence? • No The hiring authority did not identify the appropriate subjects because the investigator failed to identify the line of care staff who were responsible for caring for the patient. 9. Did the department cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? • No The department did not consult with the OLES other than to agree to consult a subject matter expert on wound care. 10. Was the pre-disciplinary/investigative phase conducted with due diligence? • No From the date the administrative investigation was opened, the investigation took 586 days to complete.
Department Corrective Action Plan	The Supervising Special Investigator will remind all investigators and provide them training on OPS policies and OLES guidelines for timely completion of monitored cases. Investigators will be instructed to include the SSI and support staff in all email communications with monitors to ensure timely and sufficient investigations. Further, the SSI will direct support staff to establish a tracking system of completed and submitted cases that are sent back by the hiring authority for further follow-up based on the recommendations by the OLES monitor. The

	SSI will ensure an OLES case extension is completed and submitted if the case will exceed the 120 days due to further follow-up at the request of the monitor. Additionally, the SSI will ensure all Investigators identify everyone in the Incident Case Plan (ICP). All trainings will be completed by the end of the calendar year.

Case Details	Description
Incident Date	08/08/2023
OLES Case Number	2023-01145-1A
Case Type	Monitored
Incident Types	1. Absent without leave (AWOL)
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Willful disobedience
Findings	1. Sustained 2. Not Sustained 3. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
Incident Summary	Two psychiatric technicians and one psychiatric technician assistant allegedly failed to lock unit doors, resulting in a patient walking out of the unit undetected until captured approximately a quarter mile from an open exit gate. One of the psychiatric technicians allegedly failed to cooperate with the Office of Special Investigations by failing to report for an investigatory interview despite four noticed interview appointments.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations against the two psychiatric technicians for failure to follow security practices; however, sustained the allegation against the psychiatric technician assistant. The hiring authority decided not to impose adverse action because the nursing coordinator issued a counseling memorandum to the psychiatric technician assistant prior to the findings conference. The hiring authority determined there was

	sufficient evidence to sustain the allegation of failing to cooperate with the Office of Special investigations against one psychiatric technician and determined a letter of expectation and training was the appropriate corrective action.
Investigative Assessment	**Overall Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. Despite a request from the monitor, the investigator did not preserve perimeter video showing where the patient was captured which was evidence of how close he came to an open gate leading to the community. Although the monitor made four requests to the Supervising Special Investigator to be notified when the findings conference was scheduled, the hiring authority held the conference without consultation with OLES.
Pre-Disciplinary Assessment	1. Was the investigation thorough and appropriately conducted? • No Despite a request from the monitor, the investigator did not preserve perimeter video showing where the patient was captured which was evidence of how far the undetected patient had traveled and how close he came to an open vehicle gate leading to the community. 2. 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 Although the monitor had made four in-person requests to the Supervising Special Investigator to be notified when the findings conference was scheduled, the monitor learned from the Office of Special Investigations AGPA that the findings conference had already occurred. Because of this, the hiring authority made decisions regarding the sufficiency of the investigation and investigatory findings without consulting the monitor. 3. Did the department cooperate with and provide continual real-time consultation with OLES throughout the

	pre-disciplinary/investigative phase? • No In February 2025, the monitor learned that the findings conference was held in June 2024, despite the monitor's four in-person requests to Supervising Special Investigator to be notified of the conference. Because of this, the hiring authority made decisions regarding the sufficiency of the investigation and investigatory findings without consulting the monitor.
Department Corrective Action Plan	The Supervising Special Investigator (SSI) will provide training to the Office of Special Investigations (OSI) personnel, to ensure OLES's oversight and investigative functions to receive full access to information, which includes any requests for video evidence without delay. Training will be conducted by the end of the calendar year. Further, the SSI shall ensure OLES monitors are updated, consulted, and notified throughout the pre-disciplinary and investigative process to ensure the monitor has an opportunity to provide recommendations. This will ensure the monitors are consulted to achieve a timely and collaborative resolution.

Case Details	Description
Incident Date	09/05/2023
OLES Case Number	2023-01276-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 repeatedly hit a patient on the head.
Disposition	The hiring authority determined there was insufficient

	evidence to sustain the allegations. The 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	09/06/2023
OLES Case Number	2023-01279-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 punched a patient two times.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed in a timely manner, and the assigned investigator did not adequately consult with the OLES monitor.
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 confer with OLES upon case initiation or prior to finalizing the investigative plan. 2. Did the investigator adequately prepare for all aspects of the investigation? • No The investigator did not confer with OLES. Therefore, it is

	unknown if the investigator was adequately prepared during the course of the investigation. 3. Did OPS cooperate with and provide continued real-time consultation with OLES? • No The investigator did not consult with OLES during the course of the investigation. 4. Was the investigation thorough and appropriately conducted? • No The investigator relied on an initial criminal report and did not conduct any independent investigation. 5. Did the hiring authority timely consult with OLES and the department attorney (if applicable), regarding the sufficiency of the investigation and the investigative findings? • No The hiring authority did not consult with OLES regarding the sufficiency of the investigation for over 60 days after the investigation was completed. 6. Did the department cooperate with and provide continual real-time consultation with OLES throughout the pre-disciplinary/investigative phase? • No The department did not consult with OLES during the course of the investigation. 7. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The incident was discovered on September 6, 2023. The criminal investigation was completed on January 23, 2024. The administrative investigation was not completed until December 17, 2024, 330 days after the completion of the criminal investigation.
Department Corrective Action Plan	The Supervising Special Investigator (SSI) will provide training to the investigator on OPS policy and OLES guidelines for timely completion of monitored cases. Further, the SSI will monitor the investigator's caseload to ensure OLES monitored cases are tracked for progress at 30, 60, and 90 days to meet deadlines with the help of support staff. The SSI will ensure the investigator submits a

	case status report to the support staff on cases that have reached 90 days. The status update will include investigative activity to date; including, what investigative steps have been taken, what interviews have been conducted, what interviews are outstanding and estimate completion date to ensure case is completed before 120 days. The SSI will review administrative cases to ensure compelled subject interviews and independent investigative steps are conducted for policy violations. The investigator will be reminded of the expectations to fully collaborate and consult with the monitor during the investigation. The SSI will review and ensure an OLES monitored case request for extension is completed with the adequate justification for cases that will exceed the 120 days. The SSI will ensure every OLES monitored case will get an Incident Case Plan (ICP) submitted to the AIMS monitor in a timely manner. The ICP will serve as a checklist for the Investigator. Additionally, all training will be conducted by the end of the calendar year.

Case Details	Description
Incident Date	01/25/2024
OLES Case Number	2024-00119-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Unfounded
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A law enforcement officer allegedly used excessive force on a patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The 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	01/26/2024
OLES Case Number	2024-00122-2A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Resigned In Lieu of Dismissal
Incident Summary	A psychiatric technician allegedly engaged in an overly familiar sexual relationship with a patient during and after his treatment at the state hospital.
Disposition	The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. The OLES concurred. The psychiatric technician resigned before discipline could be imposed. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in her official personnel file.
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	01/31/2024
OLES Case Number	2024-00183-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 initiated an unwarranted restraint of a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**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	2024-00255-2A
Case Type	Monitored
Incident Types	1. Broken Bone (Known Origin)
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 placed a chair in front of a patient who later attempted to jump over the chair, causing the patient to sustain a fractured elbow.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The OLES concurred with the hiring authority's determination.
Investigative	**Overall Rating:** Insufficient

Assessment	The department failed to comply with policies and procedures governing the investigative process because the Office of Special Investigations did not timely forward the investigative report to the hiring authority for his review and determination of the investigative findings.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was completed in 93 days and the investigative report was reviewed and approved by the monitor on October 24, 2024; however, the report was not forwarded to the hiring authority for review until December 5, 2024, 42 days later.
Department Corrective Action Plan	The Supervising Special Investigator failed to forward the case to the hiring authority in a timely manner. To correct this issue, the Supervising Special Investigator has reviewed investigation process guideline thresholds. For case tracking purposes, the Supervising Special Investigator has developed a spreadsheet tracking system to ensure all administrative cases are submitted in a timely manner. This tracking system was also vetted by the Chief of Police.

Case Details	Description
Incident Date	02/13/2024
OLES Case Number	2024-00268-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 slapped a patient.
Disposition	The hiring authority determined there was insufficient

	evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigator did not conduct an independent investigation and instead relied on previous reports conducted by others, the investigator did not consult with OLES during the course of his investigation and as a result, a potential subject/witness was not interviewed. Finally, the investigation took 340 days to complete.
Pre-Disciplinary Assessment	1. Was the incident properly documented? • No The photos taken at the time of the incident were insufficient in number and quality.
  2. Did the OPS adequately confer with OLES upon case initiation and prior to finalizing the investigative plan? • No The investigator did not confer with OLES at anytime during the investigation. 3. Did the department appropriately determine the deadline for taking disciplinary action (statute of limitation date)? • No The investigator did not discuss the statute of limitation with OLES. 4. Did the investigator adequately prepare for all aspects of the investigation? • No The investigator did not conduct any additional investigation beyond the initial DPS investigation. 5. Was the draft investigative report provided to OLES for review thorough and appropriately drafted? • No The draft report contained bias, opinion, and distorted photographic images. 6. Was the investigation thorough and appropriately conducted? • No The investigator did not conduct any additional investigation beyond the initial DPS investigation.

	7. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The administrative investigation was opened on or about June 24, 2024; however, the investigation was not completed until 340 days later.
Department Corrective Action Plan	The Supervising Special Investigator (SSI) will ensure investigators comply with OPS policies/procedures governing the investigative process, and OLES guidelines for timely completion of monitored cases. The SSI will ensure to review administrative cases to ensure compelled subject interviews are conducted for policy violations and not rely on interviews from criminal cases. Further, the SSI will remind the investigator of the expectations to fully collaborate and consult with the monitor and consider recommendations for potential additional investigative follow-up as requested. The SSI will ensure an OLES case extension is completed and submitted if the case will exceed the 120 days due to further follow-up at the request of the monitor. Additionally, the SSI will remind investigators to reach out to DPS to request all photographs and evidence pertaining to their case in a timely manner. Any additional training will be provided by the end of the calendar year.

Case Details	Description
Incident Date	03/15/2024
OLES Case Number	2024-00357-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty 5. Inexcusable neglect of duty 6. Inexcusable neglect of duty
Findings	1. Not Sustained

	2. Not Sustained 3. Not Sustained 4. Not Sustained 5. Not Sustained 6. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A senior psychiatric technician allegedly assaulted a patient as the patient tried to diffuse an altercation between two other patients. A psychiatric technician allegedly was aware the first patient was trying to resolve the conflict; however, failed to intervene when responding staff restrained and treated the first patient as an aggressor.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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	03/05/2024
OLES Case Number	2024-00358-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A psychiatric technician allegedly forced a patient to the floor after evading the patient's attack.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable cause determination. The Office of Protective Services opened

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

Case Details	Description
Incident Date	04/08/2024
OLES Case Number	2024-00543-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff allegedly failed to conduct an inquiry or medical assessment of a patient who sustained a vertebrae fracture after being pushed to the floor by a peer.
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 311 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 311 days after the incident was discovered.
Department	The Supervising Special Investigator will provide training to

Corrective Action Plan	the investigator, on OPS policy to ensure cases are completed in a timely manner. Further, the SSI will monitor the investigator's caseload to ensure OLES cases are tracked for progress at 30, 60, and 90 days to meet deadlines. The SSI will ensure the investigator submits a case status report to the support staff for OLES cases that have reached 90 days The status update will include investigative activity to date; including, what investigative steps have been taken, what interviews have been conducted, what interviews are outstanding and estimate completion date to ensure case is completed before 120 days. Additional training will be provided by the end of the calendar year.

Case Details	Description
Incident Date	04/25/2024
OLES Case Number	2024-00617-2A
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
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 inappropriately touched a patient on three occasions.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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	05/10/2024
OLES Case Number	2024-00717-1A

Case Type	Monitored
Incident Types	1. Attorney Administrative Review
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 failed to appropriately and immediately respond to an incident involving an unresponsive officer in an observation tower.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The 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	03/19/2024
OLES Case Number	2024-00725-1A
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. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
Incident Summary	An officer was allegedly sleeping on duty.
Disposition	The hiring authority sustained the allegation that the officer's conduct was unbecoming and issued a counseling memorandum. The hiring authority did not sustain the allegation that the officer was sleeping on

	duty. The 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	05/30/2024
OLES Case Number	2024-00784-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 shoved a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/05/2024
OLES Case Number	2024-00825-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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	Two psychiatric technicians allegedly hit a patient on the nose and left cheek.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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	01/05/2024
OLES Case Number	2024-00842-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A law enforcement officer was allegedly discourteous towards patients and level of care staff.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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	06/09/2024
OLES Case Number	2024-00849-1A

Case Type	Monitored
Incident Types	1. Attorney Administrative Review
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	An off-duty officer was allegedly uncooperative and discourteous towards outside law enforcement during a traffic stop.
Disposition	The hiring authority sustained the allegation and determined a letter of expectation was the appropriate penalty. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/11/2024
OLES Case Number	2024-00858-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	A law enforcement officer allegedly failed to file tax returns.
Disposition	The hiring authority sustained the allegation and issued a letter of instruction. The 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	06/13/2024
OLES Case Number	2024-00869-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Not Sustained
Penalty	**Initial:** Training **Final:** Training
Incident Summary	A psychiatric technician allegedly fell asleep while providing enhanced observation of a patient. Additionally, an associate governmental program analyst allegedly failed to report the alleged incident within two hours of witnessing its occurrence.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations against the psychiatric technician. However, the hiring authority sustained the allegations against the associate governmental program analyst for failing to report the incident within two hours and determined corrective action was the appropriate penalty. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/20/2024
OLES Case Number	2024-00897-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct

Allegations	1. Insubordination 2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An officer allegedly failed to report alleged Equal Employment Opportunity violations as required by policy. The officer also was allegedly insubordinate to a supervisor who had directed the officer to timely make the required report.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The 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	06/17/2024
OLES Case Number	2024-00901-1A
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A custodian was allegedly overly familiar with a patient, by promising to bring the patient a soda.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative	**Overall Rating:** Insufficient

Assessment	The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation was not completed until 225 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 225 days from the date of discovery.
Department Corrective Action Plan	A request for an extension will be discussed with the assigned OLES AIM, according to the parameters set out in the prior issued memorandum. OSI has also been working with HR and Admin to properly determine the types of Admin cases that are routed through OSI and can be handled directed through Program Management. This will help alleviate routing investigations through OSI that can be handled through proper Admin channels. Each OLES case is tagged with a due date and noted on the OLES board for the pending due date. A follow up is made with each investigator to check on the status of the case on a bi-weekly date. A reminder is given during each monthly staff meeting to ensure they are compliant with the due dates and a review of the OLES protocol. The investigator is offered schedule adjustments if they need to meet with level of care staff on PM and NOC shifts to complete necessary interviews. They are reminded to obtain complete and thorough interviews, but it has been necessary to conduct follow up interviews, which slows down the process of the case. The investigators will advise me, as well as the OLES AIM if an extension is required. The investigators are aware of the timelines established by OLES and are working diligently to stay within the timeframes.

Case Details	Description
Incident Date	06/20/2024
OLES Case Number	2024-00906-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical

Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A senior psychiatric technician allegedly closed the upper divider of a half-door on a patient's arm as the patient reached into the linen room and grabbed a towel without permission.
Disposition	The Office of Protective Services conducted an investigation and found sufficient evidence for a probable cause referral to the district attorney's office. The OLES concurred with the probable case determination. After the district attorney's decision on the matter, the Office of Protective Services will open an administrative investigation which the OLES will monitor.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	06/23/2024
OLES Case Number	2024-00911-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	A registered nurse allegedly neglected a patient while monitoring a patient who was on an enhanced observation. The patient fell in the shower and was injured.

Disposition	The hiring authority sustained all allegations against the nurse and determined a letter of warning was appropriate. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/21/2024
OLES Case Number	2024-00977-1A
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 psychiatric technician assistant allegedly failed to stay alert while assigned to maintain enhanced observation over a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/10/2024
OLES Case Number	2024-00995-1A
Case Type	Monitored
Incident Types	1. Attorney Administrative Review

Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An unidentified law enforcement officer allegedly provided tobacco and a lighter to a patient in exchange for $500 in cash.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegation. The 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	07/12/2024
OLES Case Number	2024-01007-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Not Sustained 3. Not Sustained 4. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A senior psychiatric technician allegedly hit a restrained patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred

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

Case Details	Description
Incident Date	07/19/2024
OLES Case Number	2024-01041-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Letter of Instruction **Final:** Letter of Instruction
Incident Summary	Two psychiatric technicians were allegedly negligent while monitoring a patient wearing a splint and sling. The patient removed his arm splint and threw it away.
Disposition	The hiring authority sustained all allegations against the psychiatric technicians and determined that letters of warning the appropriate penalty. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	07/29/2024
OLES Case Number	2024-01079-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act

Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly threw a patient to the ground, placed a knee on the patient's cheek, and punched 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	07/11/2024
OLES Case Number	2024-01110-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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	08/07/2024
OLES Case Number	2024-01114-1C

Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly grabbed a patient's walker, causing the patient to be pushed backwards.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/11/2024
OLES Case Number	2024-01130-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Incident Summary	A psychiatric technician, assigned to an enhanced observation of a patient, was allegedly on their cell phone while the patient hit a wall.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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	08/12/2024
OLES Case Number	2024-01134-1C
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 rib two weeks after alleging she was physically abused by staff.
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	08/13/2024
OLES Case Number	2024-01138-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A psychiatric technician allegedly slammed a patient against a wall, threw the patient on the ground, stomped on the patient's right hand, and put a knee on the patient's back.
Disposition	The Office of Protective Services conducted an investigation which resulted in inconclusive findings and referred the case to the district attorney's office for

	review. The OLES concurred with the determination. The Office of Protective Services will open an administrative investigation after the district attorney's review. The OLES will monitor the administrative investigation.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/18/2024
OLES Case Number	2024-01164-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A law enforcement officer allegedly used excessive force on a patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The 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	08/20/2024
OLES Case Number	2024-01174-1C
Case Type	Monitored
Incident Types	1. Over-Familiarity
Allegations	1. Criminal Act

Findings	1. Not Referred
Incident Summary	A psychiatric technician was allegedly overly familiar with a patient.
Disposition	The psychiatric technician resigned prior to the completion of the investigation; therefore, the case was not referred to the district attorney's office. A letter indicating the psychiatric technician resigned under adverse circumstances was placed in her official personnel file. Should the psychiatric technician reapply for employment, the investigation will be completed.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/24/2024
OLES Case Number	2024-01193-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 stepped on a patient while attempting to prevent the patient from swallowing a foreign object.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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	08/18/2024
OLES Case Number	2024-01199-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 grabbed a patient's shoulder.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/28/2024
OLES Case Number	2024-01245-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Sexual Assault: Priority 1
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A senior psychiatric technician and a psychiatric technician allegedly threw a patient into the seclusion room, then threw the patient against a wall. The senior psychiatric technician also allegedly pulled the patient's

	pants down and groped and slapped the patient's buttocks.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/06/2024
OLES Case Number	2024-01255-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly punched a patient in the face, causing the patient to fall and strike her head 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	09/07/2024
OLES Case Number	2024-01256-1A
Case Type	Monitored

Incident Types	1. Sexual Assault: Priority 1
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 sexually assaulted a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the investigative process. The investigation took 157 days to complete.
Pre-Disciplinary Assessment	1. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation exceeded 120 days.
Department Corrective Action Plan	To address the untimeliness, the investigator will pinpoint areas of inefficiency, such as scheduling interviews sooner. The investigator will look to complete the case review within one week and will work to identify any issues that contributed to the delay. By implementing these corrective actions, the investigator will work on identifying and working to implement an efficient system to prevent similar problems in the future. The investigator is cognizant of the time frame of 120 days in which to complete an investigation and the procedure of requesting an extension if the investigation is to move beyond 120 days. A request for an extension will be discussed with the assigned OLES AIM, according to the parameters set out in the prior issued memorandum. OSI has also been working with HR and Admin to properly determine the types of Admin cases that are routed through OSI and can be handled directed through Program

	Management. This will help alleviate routing investigations through OSI that can be handled through proper Admin channels. Each OLES case is tagged with a due date and noted on the OLES board for the pending due date. A follow up is made with each investigator to check on the status of the case on a bi-weekly date. A reminder is given during each monthly staff meeting to ensure they are compliant with the due dates and a review of the OLES protocol. The investigator is offered schedule adjustments if they need to meet with level of care staff on PM and NOC shifts to complete necessary interviews. They are reminded to obtain complete and thorough interviews, but it has been necessary to conduct follow up interviews, which slows down the process of the case. The investigators will advise me, as well as the OLES AIM if an extension is required. The investigators are aware of the timelines established by OLES and are working diligently to stay within the timeframes.

Case Details	Description
Incident Date	09/09/2024
OLES Case Number	2024-01263-2A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
Incident Summary	A psychiatric technician allegedly pushed a patient into a wall causing a laceration to the patient's head.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and issued a Letter of Instruction. The 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	09/11/2024
OLES Case Number	2024-01272-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 registered nurse allegedly inappropriately pushed a patient. The same registered nurse was also allegedly involved in an overly familiar relationship with a second patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/11/2024
OLES Case Number	2024-01282-1A
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	A psychiatric technician allegedly administered the wrong medication to a patient. Another psychiatric technician allegedly refused to provide the same patient with clean linens after the patient soiled the bed.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/11/2024
OLES Case Number	2024-01283-1A
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	Two psychiatric technicians allegedly left a patient in the courtyard unsupervised.
Disposition	The hiring authority sustained all allegations against the first psychiatric technician and determined a letter of warning was appropriate. The hiring authority determined there was insufficient evidence to sustain the allegations against the second psychiatric technician. The 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	09/07/2024
OLES Case Number	2024-01289-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 gave a patient an injection in a "stabbing" manner.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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	09/04/2024
OLES Case Number	2024-01307-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly grabbed a patient's shirt and hand in an attempt to restrain the patient. The patient sustained a broken left pinky finger.
Disposition	The case was not referred to the district attorney's office

	due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	08/16/2024
OLES Case Number	2024-01308-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Dishonesty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A law enforcement officer allegedly made dishonest statements in a written statement to a law enforcement supervisor.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The 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	09/18/2024
OLES Case Number	2024-01314-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act

Findings	1. Not Referred
Incident Summary	Unidentified staff allegedly pulled a patient's arms and pushed the patient's face into a locker during a wall stabilization.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred. .
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/01/2011
OLES Case Number	2024-01325-1A
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
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 sexually assaulted a patient while the patient was at a different state hospital. An unidentified staff member allegedly inappropriately touched the patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process. .

Case Details	Description
Incident Date	09/22/2024
OLES Case Number	2024-01334-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 restrained patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process. .

Case Details	Description
Incident Date	09/24/2024
OLES Case Number	2024-01340-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
Incident Summary	A psychiatric technician allegedly kicked a patient.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and issued a

	counseling record to include training on Administrative Directives. The 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	09/01/2024
OLES Case Number	2024-01347-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A registered nurse allegedly punched a patient in the groin.
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	09/30/2024
OLES Case Number	2024-01360-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred

Incident Summary	A registered nurse allegedly placed a knee on a patient's back during a floor 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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/01/2024
OLES Case Number	2024-01361-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Unidentified staff members allegedly punched a patient in the stomach multiple times and withheld the patient's meals.
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	09/25/2024
OLES Case Number	2024-01362-1C

Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A registered nurse allegedly pushed a patient against a wall and punched him in the groin area.
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	10/01/2024
OLES Case Number	2024-01365-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A psychiatric technician allegedly had sexual intercourse with a patient in her dormitory room multiple times over several months.
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 comply with the policies and procedures governing the investigative process. The investigating officer did not collect the patient's clothing nor ask if she had changed clothes despite alleging a psychiatric technician had raped her two days prior.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No The investigating Hospital Police Officer did not collect the patient's clothing nor ask if she had changed clothes despite alleging a psychiatric technician had raped her two days prior.
Department Corrective Action Plan	DPS personnel will be trained to conduct criminal investigations for allegations of sexual assault. Lexipol Policy 600, Investigation and Prosecution will be discussed during briefings and will be required to be read and signed by the officer conducting this investigation. Scenario training with the Office of Special Investigations will further develop DPS officers' ability to conduct sexual assault investigations. OSI is currently developing a training course for conducting investigations. DPS personnel are being sent to training on Sexual Assaults and conducting Sexual Assault Investigations. These classes are taught by a sheriff department and provide extensive training in this area. DPS personnel can attend the training and provided the training locally to our personnel. The goal is to improve the quality of sexual assault investigations conducted by DPS personnel before they are handed off to OSI. All additional training will be provided by the end of the calendar year.

Case Details	Description
Incident Date	09/17/2024
OLES Case Number	2024-01373-4A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty

Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	An unidentified law enforcement officer allegedly inappropriately touched a patient's genitals during a mandatory search.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The 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	01/26/2024
OLES Case Number	2024-01379-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 hit a patient and chipped the patient's tooth.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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	10/02/2024

OLES Case Number	2024-01383-1A
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	A psychiatric technician allegedly failed to properly monitor a patient on an enhanced level of observation. The patient swallowed two batteries.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Insufficient The department did not comply with policies and procedures governing the investigative process. The investigation was not completed until 175 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 175 days from the date of discovery
Department Corrective Action Plan	The assigned investigator will utilize a tickler file as a reminder of the due date; mark his calendar and put the due date on the top of the chronological sheet as a reminder. The investigator is cognizant of the time frame of 120 days in which to complete an investigation and the procedure of requesting an extension if the investigation is to move beyond 120 days. A request for an extension will be discussed with the assigned OLES AIM, according to the parameters set out in the prior issued memorandum. OSI has also been working with HR and Admin to properly determine the types of Admin cases that are routed through OSI and can be handled directed through

	Program Management. This will help alleviate routing investigations through OSI that can be handled through proper Admin channels. Each OLES case is tagged with a due date and noted on the OLES board for the pending due date. A follow up is made with each investigator to check on the status of the case on a bi-weekly date. A reminder is given during each monthly staff meeting to ensure they are compliant with the due dates and a review of the OLES protocol. The investigator is offered schedule adjustments if they need to meet with level of care staff on PM and NOC shifts to complete necessary interviews. They are reminded to obtain complete and thorough interviews, but it has been necessary to conduct follow up interviews, which slows down the process of the case. The investigators will advise me, as well as the OLES AIM if an extension is required. The investigators are aware of the timelines established by OLES and are working diligently to stay within the timeframes.

Case Details	Description
Incident Date	10/03/2024
OLES Case Number	2024-01385-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly slammed a patient's head against a wall, then choked the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services opened an administrative investigation, which the 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	10/04/2024
OLES Case Number	2024-01394-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff member allegedly inappropriately touched a sleeping 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	10/08/2024
OLES Case Number	2024-01396-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly grabbed a patient by his clothes and pushed the patient into the day hall.
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	10/10/2024
OLES Case Number	2024-01408-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Applicable 3. Not Referred
Incident Summary	A registered nurse allegedly tackled a patient in a seclusion room and pinned his face against the wall. A psychiatric technician allegedly pinned the patient against a wall following a shower.
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	10/14/2024
OLES Case Number	2024-01415-1C
Case Type	Monitored

Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly forcefully grabbed a patient by the back of the shirt and pushed 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	10/18/2024
OLES Case Number	2024-01427-1A
Case Type	Monitored
Incident Types	1. Death
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A patient complained of chest pains, shortness of breath, and dizziness before falling and hit his head. The patient was transported to an outside hospital where he experienced a medical emergency. Life saving measures were initiated; however, the patient later died.
Disposition	The Office of Protective Services completed the required post-death investigation, determining there was no evidence of a crime or policy violation that contributed to the patient's death. The OLES concurred.

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

Case Details	Description
Incident Date	10/16/2024
OLES Case Number	2024-01428-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 psychiatric technicians allegedly physically abused and suffocated a patient while giving an intramuscular injection.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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	10/17/2024
OLES Case Number	2024-01429-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty

	2. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling
Incident Summary	Unidentified staff allegedly physically abused a patient by hitting him in the rib area and by putting their knee into the patient's calf. The staff also allegedly refused to provide the patient with a medical assessment. A registered nurse allegedly failed to cooperate during the administrative investigation.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations of abuse against staff. The OLES concurred with the hiring authority's determination. The hiring authority determined there was sufficient evidence to sustain the allegation of failure to cooperate during an administrative investigation by a registered nurse and issued a Letter of Warning. The 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	10/17/2024
OLES Case Number	2024-01432-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred

Incident Summary	A psychiatric technician allegedly knocked a cup out of a patient's hand as a senior psychiatric technician allegedly argued with the patient. When the patient allegedly defended himself, he was placed in a floor containment where several staff, including the senior psychiatric technician, the psychiatric technician, and a unit supervisor allegedly struck the patient.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause that a staff member committed a crime on this case. The OLES concurred with the probable cause determinations. The Office of Protective Services did not open an administrative investigation. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	09/23/2024
OLES Case Number	2024-01433-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 physically abused a patient by grabbing the patient's shirt collar and throwing the patient onto a bed.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/19/2024
OLES Case Number	2024-01436-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Unidentified staff members allegedly grabbed a patient by the arms and forced her to 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	10/24/2024
OLES Case Number	2024-01458-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit a seated patient on the bicep.
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	10/24/2024
OLES Case Number	2024-01465-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A registered nurse allegedly inappropriately grabbed a patient's 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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	10/24/2024
OLES Case Number	2024-01467-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Counseling **Final:** Counseling

Incident Summary	An officer allegedly failed to properly admonish a suspect before an interview and inaccurately documented the admonishment in an official report.
Disposition	The hiring authority sustained the allegation and issued written counseling. The OLES concurred with the hiring authority's determinations.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with policies and procedure governing the investigative process.

Case Details	Description
Incident Date	10/30/2024
OLES Case Number	2024-01497-1C
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A psychiatric technician allegedly raped a patient multiple times.
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	11/02/2024
OLES Case Number	2024-01499-1C
Case Type	Monitored

Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly placed his knee on a patient's neck while the patient was 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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	11/05/2024
OLES Case Number	2024-01507-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician assistant allegedly struck a patient on the back of the neck.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. 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	11/02/2024
OLES Case Number	2024-01508-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff member allegedly hit a patient on the forehead with an unknown object.
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	11/05/2024
OLES Case Number	2024-01514-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychologist allegedly hit a patient on the head.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. 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	11/08/2024
OLES Case Number	2024-01525-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical 2. Sexual Assault: Priority 1
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	Two unidentified staff members slapped a patient's food from his hands during breakfast, threatened the patient, and touched the patient without gloves.
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 comply with the policies and procedures governing the investigative process. . The responding officers failed to search for the suspects described by the patient on the date of the incident. The officers' report was approved by a supervisor despite this failure.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No The responding Office of Protective Services officers failed to search for the suspects described by the patient on the date of the incident. The officers' report was approved by a supervisor despite this failure.

Department Corrective Action Plan	DPS personnel will be trained to conduct criminal investigations to include searching for the suspects and thoroughly documenting those efforts. Lexipol Policy 600, Investigation and Prosecution will be briefed to all DPS personnel. This will include the supervisors who must understand the elements of the investigations they are approving. Scenario training with the Office of Special Investigations will develop DPS officers' ability to conduct thorough and complete investigations. OSI is currently developing a training class for conducting investigations. DPS personnel are continuously attending Criminal Investigations training, Report Writing classes, and Interview and Interrogations training. The goal is to improve the overall quality of investigations by training officers and supervisors. All additional training will be provided by the end of the calendar year.

Case Details	Description
Incident Date	11/02/2024
OLES Case Number	2024-01549-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 in the face.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process. .

Case Details	Description
Incident Date	11/22/2024
OLES Case Number	2024-01563-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 used unreasonable force during a restraint, causing the patient to hit her knees against the wall, resulting in bruises.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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	11/25/2024
OLES Case Number	2024-01568-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act 5. Criminal Act 6. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred

	4. Not Referred 5. Not Referred 6. Not Referred
Incident Summary	A psychiatric technician and five unidentified male staff members allegedly battered 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	11/24/2024
OLES Case Number	2024-01571-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A psychiatric technician allegedly sprayed a patient in the face with air freshener.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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	12/02/2024

OLES Case Number	2024-01600-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff member allegedly used a carotid restraint to choke a patient three times.
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	12/05/2024
OLES Case Number	2024-01609-3A
Case Type	Monitored
Incident Types	1. Use of Force Review
Allegations	1. Inexcusable neglect of duty
Findings	1. Not Sustained
Penalty	**Initial:** No Penalty Imposed **Final:** No Penalty Imposed
Incident Summary	A law enforcement officer allegedly used excessive force on a patient.
Disposition	The hiring authority found insufficient evidence to sustain the allegation. The 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	12/09/2024
OLES Case Number	2024-01623-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 and two psychiatric technicians allegedly hit a patient multiple times while the patient was in restraints.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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	12/09/2024
OLES Case Number	2024-01624-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly pulled a patient to the floor, dragged the patient by the shirt to a seclusion room and choked 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	12/15/2024
OLES Case Number	2024-01642-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred
Incident Summary	During a floor containment procedure, an unidentified staff allegedly repeatedly struck a patient in the face while a second unidentified staff kicked the patient five times in the testicles, and a third unidentified staff spit on him. While being placed in restraints, a psychiatric technician allegedly pinched the patient on the arm.
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	12/18/2024
OLES Case Number	2024-01659-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A psychiatric technician allegedly intentionally struck a patient's leg when opening a cabinet drawer.
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	11/29/2024
OLES Case Number	2024-01660-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff member allegedly punched a patient on four separate occasions.
Disposition	The case was not referred to the district attorney's office

	due to a lack of probable cause. The OLES concurred with the probable cause determination. . The department opened an administrative investigation which the OLES did not accept for monitoring because the incident did not meet the OLES's monitoring criteria.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/18/2024
OLES Case Number	2024-01662-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified male staff member allegedly kicked a patient once on the shin.
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	12/22/2024
OLES Case Number	2024-01674-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act

Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly placed a patient in a headlock, threw him to the ground, punched him multiple times, and kneed him in the back and side.
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	12/22/2024
OLES Case Number	2024-01680-1A
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	A psychiatric technician and a registered nurse allegedly failed to maintain proper supervision of a patient and the patient swallowed a toothbrush.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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	12/23/2024

OLES Case Number	2024-01681-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Referred
Incident Summary	A psychiatric technician allegedly slapped a patient once on the back of the fall protection helmet he was wearing.
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	12/30/2024
OLES Case Number	2024-01696-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified staff member allegedly dragged a patient along the floor, grabbed his arm, and scratched his forehead during an escort to 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 did not open an administrative investigation. OLES concurred.

Investigative Assessment	**Overall Rating:** Insufficient The department did not comply with the policies and procedures governing the investigative process. The reporting officer did not complete an interview with the unit supervisor to identify the suspect, requiring the Office of Special Investigations to request that the interview be conducted and a report written.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No The reporting hospital police officer did not complete an interview with the unit supervisor to identify the suspect, requiring the Office of Special Investigations to request the interview be conducted and a report written.
Department Corrective Action Plan	DPS personnel will be trained to conduct investigations to include how to properly document and conduct interviews with all necessary witnesses upon initial response. Lexipol Policy 600, Investigation and prosecution will be discussed during briefings and will be required to be read and signed by the officer conducting this investigation. Scenario training with the office of Special Investigations will further develop DPS officers' ability to conduct thorough investigations. OSI is currently developing a training class for conducting investigations. DPS personnel are send to courses on Criminal Investigations, Report Writing and Interview and Interrogation techniques. The goal is to improve the quality of investigations by DPS personnel. All additional training will be provided by the end of the calendar year.

Case Details	Description
Incident Date	12/29/2024
OLES Case Number	2024-01697-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act

Findings	1. Not Referred 2. Not Referred
Incident Summary	A psychiatric technician and a second staff member allegedly repeatedly punched and kicked a patient and contained the patient on the floor at which time other staff members joined in punching and kicking 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	12/31/2024
OLES Case Number	2025-00001-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A registered nurse allegedly jumped onto a patient and pushed his elbow into the patient's body.
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	01/02/2025
OLES Case Number	2025-00013-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A registered nurse allegedly grabbed and 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	01/02/2025
OLES Case Number	2025-00014-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly hit a patient on the shoulder and pulled the patient's arms over their 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 complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	12/18/2024
OLES Case Number	2025-00035-1C
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Two psychiatric technicians allegedly failed to complete neurological checks on a patient who had fallen and struck his head on a wall.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the 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	12/18/2024
OLES Case Number	2025-00035-2A
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:** Counseling **Final:** Counseling
Incident Summary	A psychiatric technician allegedly failed to complete neurological checks on a patient who had fallen and struck his head on a wall.
Disposition	The hiring authority determined there was insufficient evidence that the psychiatric technician abused the patient, but did find sufficient evidence to sustain the allegation the psychiatric technician failed to timely assess the patient, and determined corrective action in the form a policy review was appropriate. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/10/2025
OLES Case Number	2025-00048-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Two unidentified staff allegedly punched a patient in his face.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred. .
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/14/2025
OLES Case Number	2025-00062-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred
Incident Summary	An unidentified male staff member allegedly entered a patient's room and used both hands to repeatedly hit the patient in the face and 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 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	01/11/2025
OLES Case Number	2025-00067-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A nurse allegedly used hot water to prepare a perineal

	bath for a patient, which caused him pain and discomfort.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/14/2025
OLES Case Number	2025-00075-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly intentionally threw water from a cup onto a patient during medication call.
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	01/20/2025
OLES Case Number	2025-00077-1C
Case Type	Monitored

Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act
Findings	1. Not Referred 2. Not Referred
Incident Summary	A psychiatric technician and a second unidentified male staff member allegedly hit or pushed a patient while escorting the patient to 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 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	01/22/2025
OLES Case Number	2025-00092-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly overmedicated patients to make them more docile.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The department opened an administrative investigation, which the OLES accepted for monitoring.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with the policies

	and procedures governing the investigative process.

Case Details	Description
Incident Date	01/22/2025
OLES Case Number	2025-00093-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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's foot with a baseball bat.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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	01/21/2025
OLES Case Number	2025-00095-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	Unidentified staff allegedly forced a restrained patient to take medication.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred

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

Case Details	Description
Incident Date	01/23/2025
OLES Case Number	2025-00097-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act 2. Criminal Act 3. Criminal Act 4. Criminal Act 5. Criminal Act 6. Criminal Act
Findings	1. Not Referred 2. Not Referred 3. Not Referred 4. Not Referred 5. Not Referred 6. Not Referred
Incident Summary	A psychiatric technician and four unidentified male staff members grabbed a patient from the shower, threw her on a bed, and pinched her all over her body.
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	01/02/2025
OLES Case Number	2025-00115-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly twice asked a patient to see his genitalia. .
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. The OLES concurred with the probable cause determination. The Office of Protective Services did not open an administrative investigation due to lack of evidence. The OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	01/30/2025
OLES Case Number	2025-00130-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A registered nurse allegedly hit a patient once in the face and two months prior, kicked the patient in the 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:** Insufficient The department did not comply with the policies and procedures governing the investigative process. The Department of Protective Services officers who interviewed a victim-patient with significant speech impediments asked that he nod or shake his head in response to their questions. However, because the patient's gestures were not verbalized during the interview, it is unclear from the interview recording how the officers obtained the detailed allegations documented in the report. When re-interviewed by the Office of Special Investigations, the victim-patient responded in writing that he did not remember the alleged abuse. The Department of Protective Services officers documented important information about the alleged physical abuse, including how the suspect was identified, in an unrelated informational report and did not include that information in the physical abuse report.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No The Department of Protective Services officers who interviewed a victim-patient with significant speech impediments asked that he nod or shake his head in response to their questions. However, because the patient's gestures were not verbalized during the interview, it is unclear from the interview recording how the officers obtained the detailed allegations documented in the report. When re-interviewed by the Office of Special Investigations, the victim-patient responded in writing that he did not remember the alleged abuse. 2. Was the incident properly documented? • No The Department of Protective Services officers documented important information about the alleged physical abuse, including how the suspect was identified, in an unrelated informational report and did not include that information in the physical abuse report.

Department Corrective Action Plan	DPS personnel will be trained on how to conduct and document criminal investigations. Specifically, Lexipol Policy 322, Report Writing and Lexipol Policy 600 Investigation and Prosecution will be briefed to all DPS personnel. The DPS officer conducting this investigation will be required to read and sign these two policies. Scenario training with the Office of Special Investigations will develop DPS officers' ability to conduct interviews and thorough investigations. OSI is currently developing a training course on conducting investigations. DPS personnel are being sent to IA Investigations training, Report Writing training, and Interview and Interrogation techniques classes. The goal is to improve the quality of investigations by DPS personnel. All additional training will be provided by the end of the calendar year, specifically regarding alternative ways to interview patients with significant speech impediments.

Case Details	Description
Incident Date	02/03/2025
OLES Case Number	2025-00143-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician assistant allegedly hit the patient on the 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 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	02/04/2025
OLES Case Number	2025-00148-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	An unidentified male staff member allegedly kicked a patient once in the chest and slammed the patient's head twice on the floor during a floor 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. OLES concurred.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	
OLES Case Number	2025-00167-1A
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
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 psychiatric technicians and one senior psychiatric technician allegedly sexually assaulted a patient.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The OLES concurred with the hiring authority's determination.
Investigative Assessment	**Overall Rating:** Sufficient The department complied with policies and procedures governing the investigative process.

Case Details	Description
Incident Date	02/28/2025
OLES Case Number	2025-00255-1A
Case Type	Monitored
Incident Types	1. Abuse - Physical
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 hit a patient multiple times on the head.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations. The 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	03/24/2025
OLES Case Number	2025-00352-1C

Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly slapped a patient once on the back of the head and kicked the patient once in the groin.
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 comply with the policies and procedures governing the investigative process. Eight minutes after the responding officers interviewed the psychiatric technician as a victim of a battery by the patient, the patient told the officers that the psychiatric technician punched him in the head and kicked him in the groin. The officers did not recontact and interview the psychiatric technician regarding the alleged physical abuse. The officers' summary of the psychiatric technician's statement in the physical abuse report was essentially the same summary used in the staff battery report, which did not address the abuse allegation.
Pre-Disciplinary Assessment	1. Did the department adequately respond to the incident? • No Eight minutes after the responding officers interviewed the psychiatric technician as a victim of a battery by the patient, the patient told the officers that the psychiatric technician punched him in the head and kicked him in the groin. The officers did not recontact and interview the psychiatric technician regarding the alleged physical abuse. 2. Was the incident properly documented? • No The officers' summary of the psychiatric technician's statement in the physical abuse report was essentially the

	same summary used in the staff battery report, which did not address the abuse allegation.
Department Corrective Action Plan	DPS personnel will be trained to investigate the entire scope of an incident. Lexipol Policy 600, Investigation and Prosecution will be discussed during briefings and will be required to be read and signed by the DPS officer conducting this investigation. Scenario training with the Office of Special Investigations will further develop DPS officers' ability to conduct thorough and complete investigations. OSI is currently developing a training class for conducting investigations. DPS personnel are continuously being sent to IA Investigations training, Report Writing training, and Interview and Interrogations classes. The goal is to improve the quality of investigations by DPS personnel. Additional training will be provided by the end of the calendar year.

Case Details	Description
Incident Date	03/18/2025
OLES Case Number	2025-00356-1C
Case Type	Monitored
Incident Types	1. Broken Bone (Unknown Origin)
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A patient was found lying on the floor with facial injuries which included a fractured 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 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	04/06/2025
OLES Case Number	2025-00409-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly hit a patient once in the stomach when the patient tried to take a snack from a bin before snack time.
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	04/08/2025
OLES Case Number	2025-00424-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A senior psychiatric technician allegedly pushed a patient to the ground.
Disposition	The case was not referred to the district attorney's office due to a lack of probable cause. 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	04/08/2025
OLES Case Number	2025-00425-1C
Case Type	Monitored
Incident Types	1. Abuse - Physical
Allegations	1. Criminal Act
Findings	1. Not Referred
Incident Summary	A psychiatric technician allegedly pushed a patient to the ground and used physical force to prevent the patient from getting up.
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.

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	06/27/2023
OLES Case Number	2023-00939-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Inexcusable neglect of duty 2. Insubordination
Findings	1. Sustained 2. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	A law enforcement officer allegedly did not return facility property in a timely manner.
Disposition	The hiring authority sustained the allegations and determined a salary reduction of 5 percent for three months was the appropriate penalty. The officer filed an appeal with the State Personnel Board. Following an

	evidentiary hearing, the State Personnel Board sustained the penalty.
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	09/24/2023
OLES Case Number	2023-01369-1A
Case Type	Monitored
Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained 3. Not Sustained 4. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Letter of Instruction
Incident Summary	A senior psychiatric technician allegedly failed to report and document a patient's fall and injury. The senior psychiatric technician also was allegedly uncooperative with investigators and was not truthful during the investigative interview.
Disposition	The hiring authority determined there was insufficient evidence to sustain the allegations the senior psychiatric technician failed to report and document the patient's fall and injury. However, the hiring authority found there was sufficient evidence to sustain the allegations the senior psychiatric technician failed to cooperate with investigators and was not truthful during the investigative

	interview. The hiring authority determined a 5 percent salary reduction for three months was the appropriate penalty. The OLES concurred with the hiring authority's determinations. After the Skelly hearing, the department reduced the penalty to a letter of counseling. The OLES concurred based on factors learned at the Skelly hearing.
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 200 days from the date of discovery and the investigator did not adequately prepare for all aspects of the investigation.
Pre-Disciplinary Assessment	1. Did the investigator adequately prepare for all aspects of the investigation? • No The investigator did not adequately prepare for all aspects of the investigation. Specifically, the investigator did not review relevant documentary evidence, unit rounds sheets (fire, life and safety checks) prior to conducting interviews. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The incident was discovered on September 24, 2023; however, the investigation was not completed until April 11, 2024, 200 days later.
Disciplinary Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the disciplinary process. The notice of adverse action was not served on the senior psychiatric technician until 164 days after the hiring authority made disciplinary findings.
Disciplinary Assessment Questions	1. Was the disciplinary phase conducted with due diligence by the department? • No On May 24, 2024, the hiring authority determined a salary reduction was appropriate. However, the notice of adverse action was not served on the senior psychiatric technician until November 4, 2024,164 days later.
Department	The investigator will review the initial Police report to

Corrective Action Plan	check if there is the possibility of additional witnesses and/or subjects that need to be interviewed. Once the information is acquired through interviews, the investigator will make every attempt to contact and interview pertinent subjects or witnesses. The investigator will also request and review documentation that is necessary to complete the investigation. The investigator is cognizant of the 120-day time frame in which to complete an investigation, and the process in which to request an extension. The OLES AIM will be consulted if an extension is requesting, based on the parameters set by the prior issued memorandum. OSI has also been working with HR and Admin to properly determine the types of Admin cases that are routed through OSI and can be handled directed through Program Management. This will help alleviate routing investigations through OSI that can be handled through proper Admin channels. Each OLES case is tagged with a due date and noted on the OLES board for the pending due date. A follow up is made with each investigator to check on the status of the case on a bi-weekly date. A reminder is given during each monthly staff meeting to ensure they are compliant with the due dates and a review of the OLES protocol. The investigator is offered schedule adjustments if they need to meet with level of care staff on PM and NOC shifts to complete necessary interviews. They are reminded to obtain complete and thorough interviews, but it has been necessary to conduct follow up interviews, which slows down the process of the case. The investigators will advise me, as well as the OLES AIM if an extension is required. The investigators are aware of the timelines established by OLES and are working diligently to stay within the timeframes.

Case Details	Description
Incident Date	12/08/2023
OLES Case Number	2023-01709-2A
Case Type	Monitored

Incident Types	1. Neglect
Allegations	1. Inexcusable neglect of duty
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Salary Reduction
Incident Summary	A licensed vocational nurse allegedly neglected her duty to maintain proper supervision of a patient who swallowed batteries.
Disposition	The hiring authority determined there was sufficient evidence to sustain the allegation and imposed a 10 percent salary reduction for 12 months. The OLES concurred with the hiring authority's determination. Prior to the filing of an appeal, the department entered into a settlement agreement with the licensed vocational nurse wherein the penalty was reduced to a five percent salary reduction for six months. The OLES concurred because the settlement was reasonable.
Investigative Assessment	**Overall Rating:** Sufficient The department sufficiently complied with the policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with the policies and procedures governing the disciplinary phase. The final disposition meeting took place on July 10, 2024, and the disciplinary action was not served on the employee until February 4, 2025, 209 days later. The OLES was never provided the proposed Notice of Adverse Action prior to service on the employee, and the hiring authority did not consult with OLES before modifying the penalty and agreeing to a settlement.
Disciplinary Assessment Questions	1. Did the department attorney or discipline officer provide OLES with a copy of the draft disciplinary action and consult with OLES? • No The OLES was never provided the proposed Notice of Adverse Action prior to service on the employee. 2. Did the hiring authority consult with OLES and the department attorney (if applicable) before modifying the

	penalty or agreeing to a settlement? • No The hiring authority did not consult with OLES before modifying the penalty and agreeing to a settlement. 3. Was the disciplinary phase conducted with due diligence by the department? • No The disciplinary phase was not conducted with due diligence by the department. The final disposition meeting took place on July 10, 2024, and the disciplinary action was not served on the employee until February 4, 2025, 209 days later.
Department Corrective Action Plan	A miscommunication occurred between the investigative unit and the hiring authority. All cases that go to the hiring authority will now contain details regarding the OLES monitoring status of the case.

Case Details	Description
Incident Date	02/06/2024
OLES Case Number	2024-00221-1A
Case Type	Monitored
Incident Types	1. Sexual Assault: Priority 1
Allegations	1. Inexcusable neglect of duty 2. Inexcusable neglect of duty 3. Inexcusable neglect of duty 4. Inexcusable neglect of duty
Findings	1. Not Sustained 2. Sustained 3. Sustained 4. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	A psychiatric technician allegedly hit a patient's genitals, failed to cooperate with an official investigation, and was discourteous to the investigator.
Disposition	The hiring authority sustained the allegation of failing to

	cooperate with an official investigation and discourteous treatment but did not sustain allegations of abuse. The hiring authority determined a 5 percent salary reduction for six months was the appropriate penalty. The OLES concurred with the hiring authority's determination. The psychiatric technician filed an appeal with the State Personnel Board. Prior to the State Personnel Board proceedings, the department entered into a settlement agreement with the psychiatric technician wherein the penalty was reduced to 5 percent salary reduction for three months. The psychiatric technician agreed to withdraw his appeal. The OLES concurred with the settlement.
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	02/29/2024
OLES Case Number	2024-00343-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Discourteous treatment
Findings	1. Sustained
Penalty	**Initial:** Salary Reduction **Final:** Letter of Reprimand
Incident Summary	An officer allegedly posted images of his police services badge and made inappropriate comments on a social media site.
Disposition	The hiring authority sustained the allegations and determined the appropriate penalty was a salary reduction of 5 percent for three months. The OLES concurred with the hiring authority's determinations.

	Following a Skelly hearing, the department entered into an agreement with the officer in which the department agreed to reduce the penalty to a letter of reprimand and the officer waived his right to appeal. The OLES concurred with the settlement as the officer expressed remorse and the misconduct was unlikely to recur.
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	05/09/2024
OLES Case Number	2024-00715-1A
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 Reprimand **Final:** Counseling
Incident Summary	An officer allegedly sent an inappropriate sexually suggestive email to the hospital police department.
Disposition	The hiring authority sustained the allegation and determined a letter of reprimand was the appropriate penalty. The OLES concurred. Following a Skelly hearing, the department agreed to withdraw the letter of reprimand and replace it with written counseling. The OLES concurred with the settlement based on the officer's sincere expression of remorse and acceptance of responsibility at the Skelly hearing making the recurrence of the misconduct less likely.
Investigative	**Overall Rating:** Sufficient

Assessment	The department complied with policies and procedures governing the investigative process.
Disciplinary Assessment	**Overall Rating:** Insufficient The department failed to comply with policies and procedures governing the disciplinary process. Although a Skelly hearing was held, the OLES was not notified of the hearing.
Disciplinary Assessment Questions	1. 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 Although a Skelly hearing was held, the department did not notify OLES of the hearing.
Department Corrective Action Plan	All AAR cases will be marked as OLES monitored and included in all disciplinary determination and hearings.

Case Details	Description
Incident Date	05/10/2024
OLES Case Number	2024-00716-1A
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:** Salary Reduction **Final:** Modified Salary Reduction
Incident Summary	An officer was allegedly less than alert while working an overtime shift in an observation tower and failed to complete nightly security calls.
Disposition	The hiring authority sustained the allegation and determined a salary reduction of 5 percent for six months was the appropriate penalty. The OLES concurred.

	Following a Skelly hearing, the department entered into a settlement agreement with the officer whereby the department agreed to lower the salary reduction to 5 percent for three months and the officer agreed to waive his right to appeal. The OLES concurred with the settlement based on the officer's sincere expression of remorse and acceptance of responsibility at the Skelly hearing making the recurrence of the misconduct less likely.
Investigative Assessment	**Overall Rating:** Insufficient The department failed to comply with policies and procedures governing the investigative process. The investigation was not completed until 161 days from the date of discovery, and the hiring authority did not consult with OLES regarding the investigative findings until 68 days following completion of the investigation.
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 took 68 days after the completion of the investigation to consult with OLES regarding the sufficiency of the investigation and investigative findings. 2. Was the pre-disciplinary/investigative phase conducted with due diligence? • No The investigation was not completed until 161 days after the incident was discovered.
Disciplinary Assessment	**Overall Rating:** Insufficient The department did not sufficiently comply with policies and procedures governing the disciplinary process. The hiring authority did not notify OLES of the Skelly hearing.
Disciplinary Assessment Questions	1. Did the department attorney or discipline officer cooperate with and provide continual real-time consultation with OLES throughout the disciplinary phase, until all proceedings were completed, except for those related to a writ? • No The department did not notify OLES of the Skelly hearing, thereby preventing contemporaneous

	monitoring.
Department Corrective Action Plan	All AAR cases will be marked as OLES monitored and included in all disciplinary determination and hearings. Related to the deficiency of 68 days past completion of the report before consulting with OLES, DSH-A Police Chief or designee will start emailing Employee Relations Office the completed IA investigations for tracking purposes. OPS will continue to work closely with OLES AIM and strive to meet the 120 days threshold to complete the investigations.

Case Details	Description
Incident Date	06/03/2024
OLES Case Number	2024-00819-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Other failure of good behavior
Findings	1. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	An officer was arrested for allegedly being under the influence and in possession of oxycodone.
Disposition	The hiring authority sustained the allegation and dismissed the officer. The 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.

Case Details	Description
Incident Date	07/01/2024
OLES Case Number	2024-00948-2A
Case Type	Monitored
Incident Types	1. Peace Officer Misconduct
Allegations	1. Addiction to controlled substances 2. Conviction of a crime 3. Inexcusable neglect of duty 4. Discourteous treatment 5. Other failure of good behavior
Findings	1. Sustained 2. Sustained 3. Sustained 4. Sustained 5. Sustained
Penalty	**Initial:** Dismissal **Final:** Dismissal
Incident Summary	An officer was arrested for allegedly being under the influence of a narcotic, possession of a narcotic controlled substance, and possession of controlled substance.
Disposition	The hiring authority sustained the allegation and determined dismissal was the appropriate penalty. The OLES concurred with the hiring authority's determinations. The officer did not file an appeal with the State Personnel Board.
Investigative Assessment	**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.

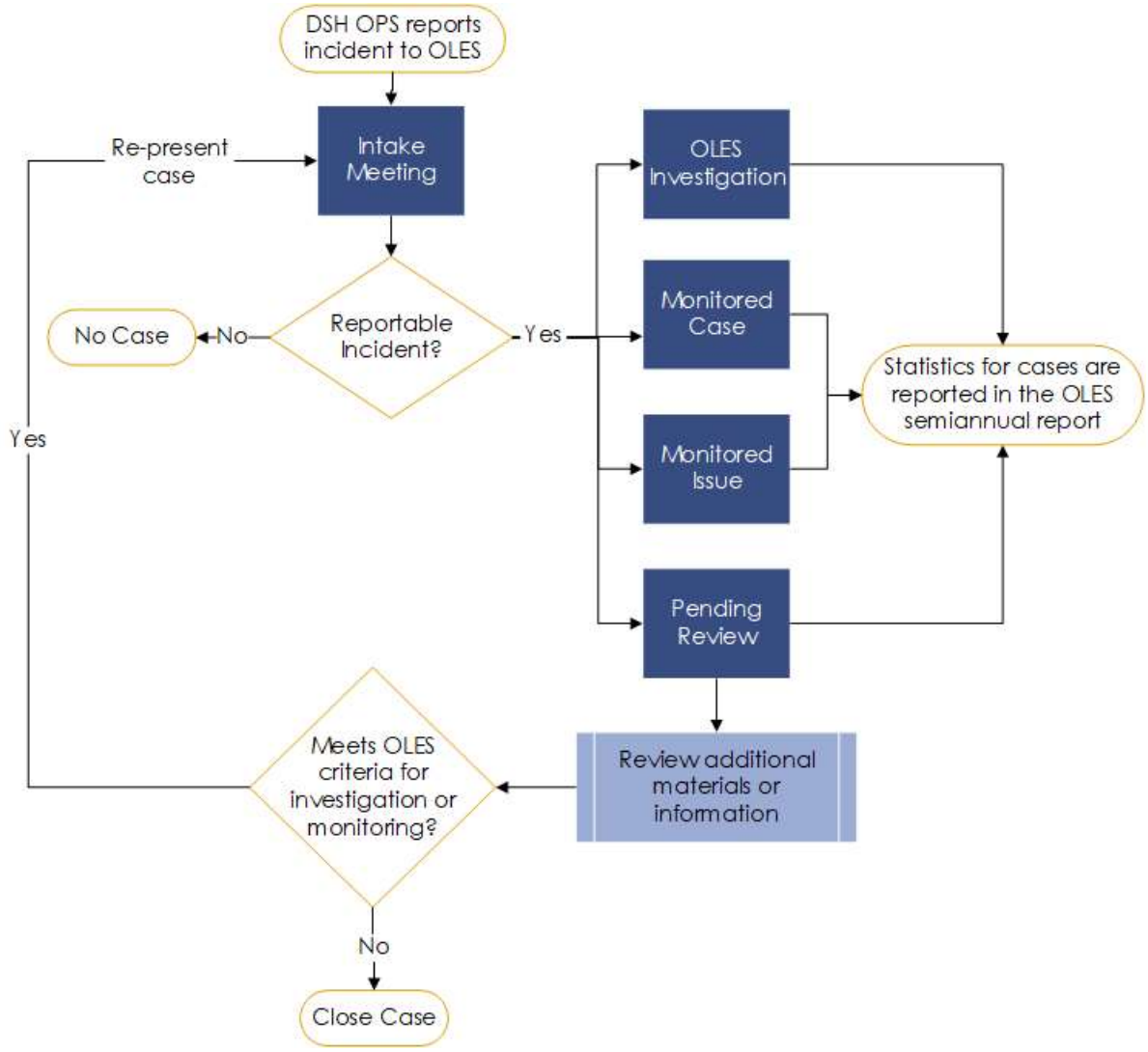
(b) A report pursuant to this section shall be made no later than the close of the first business day following the discovery of the reportable incident.

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[5], throughout the investigation and disciplinary process. Bargaining unit agreements and best practices led to a recommendation that most investigations should be completed within 120 days of the discovery of the allegations of misconduct. The illustration below shows an optimal situation where the 120-day recommendation is followed. However, complex cases can take more time.

Administrative Investigation Process

THRESHOLD INCIDENTS (120 Days)

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

Critical Junctures

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

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

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

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

45 Days

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

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

60 Days

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

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

30 Days

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

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

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

Conclusion

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