MINUTES **Attachment A**
CITIZENS' LAW ENFORCEMENT REVIEW BOARD TOWN HALL
March 22, 2022

Roll Call

- The meeting was held via the Zoom platform and came to order at 5:30 p.m. All Board members were present except Susan Youngflesh.

Public Comments

- Francine Maxwell, Tasha Williamson, Yusef Miller, Dr. Brown, Doris Bittar, Gary Brown, and Harry Burnett addressed the Board.
  - All were thanked for putting together the Town Hall, including Dr. Weber and colleagues for pulling together AB 2343 to address issues we see. Condolences were offered to family members present. Inquiries about hospital deaths and if any other counties have the same procedures. Issues concerning "compassionate release", "No Humans Involved", procedures for recruiting police and mental health professionals, a need for an overhaul of the system, based on race, and concerns that a human being is getting more drugs after being arrested with drugs already in their system were discussed. Questions were also raised regarding body scanners, and what exactly do they pick up.
- Family members of Saxon Rodriguez, who passed away in July 2021, spoke. The family is not getting any assistance and would like answers, They feel disregarded because case was considered an overdose. EO Parker assured them that Lenore Aldridge will keep in touch regarding the investigation and hopes to have an update included on May's Agenda

New Business

- Continuance of Teleconferencing Meeting Option Pursuant to Code Section 54953(e)
  - Shiri Hoffman, *"the Finding that CLERB would have to make to continue teleconferencing would be a motion that CLERB has reconsidered the circumstances of the state of emergency and that state and local officials continue to recommend measures to promote social distancing"*.
  - Motion carried. The next meeting will be virtual.
- CLERB Town Hall Pertaining to California State Auditor Report 2021-109: San Diego County Sheriff's Department
  - Ms. Domingos welcomed everyone and acknowledged Francine Maxwell for attending the third meeting in a row and, as a Board member, it is important to address issues/concerns as they come up.
  - EO Paul, thanked Mr. Tilden and Ms. Sanders; acknowledged Dr. Akilah Weber's office, for her attempt to address just about all the recommendations the Auditor discussed. He also noted CRJSD and SFRJNC. EO Parker acknowledged that the SDSD are not present but did respond they're supportive of the Auditor's recommendations and already instituted some of them.
  - Michael Tilden, released the final report on February 3 this year.
  - The Audit Committee approved an audit request of the SD County Sheriff's Department. The focus being on the number of in-custody deaths. There were two key questions, (1) why so many individuals have been dying in the custody of the San Diego County Sheriff's Department over a number of years and, (2) what corrective action SDSD has taken in response to those deaths. One of the first things they did was gather some data from the DOJ, on the number of deaths in the San Diego Detention Centers over the last 15 years (2006-2021). They found more than 200 individuals died in SD County Detention facilities, including 18 deaths just in 2021—the second highest number of deaths in a county jail, other than LA County, which has a much larger daily jail population.
  - Beyond looking at the total number of in-custody deaths, they looked at death rates based on the average daily jail population. Based on a graphic in their report, county jail deaths are the highest in the State. To figure out what's causing these deaths, where were they occurring, they reviewed results for the case files for 30 in-custody deaths over the last 15 years. The team also reviewed video surveillance and identified a number of key breakdowns. 1. Insufficient health evaluations during intake-not doing a good job at identifying individuals with medical or mental health issues. SD doesn't require a mental health professional be involved at the intake to assess the individuals' potential mental health needs. In their sample of 30, they found 8 individuals had serious mental/medical issues that weren't identified during intake. 5 of them died within four days of their arrest. They found the individuals weren't getting proper follow up care. They complained to sworn staff of various mental health/medical symptoms but weren't given access to a doctor, and often end up dying, in some cases, before even seeing a doctor.
  - Another key breakdown is one of the key controls in San Diego. The officers are required to do

DRAFT

safety checks every hour where they literally walk by every cell to make sure they're ok. But, in looking at the video, several officers would make a quick look, and several hours later would realize an individual was non-responsive.

- They also noticed sworn staff were slow to respond to medical emergencies because, in certain cases, life-saving measures were unnecessarily delayed.

- The Board of State and Community Corrections are responsible for setting minimum standards for all Detention Centers in the entire state. They ensure the health and safety of individuals in custody. These standards are very minimal. However, their expectation is at the individual county jail level, they develop more robust policies and procedures. They found the jail systems are not doing a robust job at developing P&Ps to protect individuals in their custody. He noted Riverside County does require a mental health professional at intake to identify any mental health issues. This a practice SD/other counties should employ.
- The Department of Corrections has policies that requires them, when making hourly rounds, to make sure each individual is alive and well. San Diego needs to have Policies and Procedures to make sure these critical safety checks are more refined. Where did the breakdowns occur? Even though SDSD conducts diff reviews, they're generally not well documents, or made avail to the public. They don't seem to be focused on corrective actions to minimize sim. Deaths in the future. They also have not done a great job at implementing recommendations. For example, the San Diego County Grand Jury, a suicide prevention specialist and CLERB have all come forth with recommendations that the SDSD didn't do a good job at implementing.
- Regarding CLERB's oversight of deaths in SD County jails, one of CLERB's key responsibilities was to review in-custody deaths. But they found a number of shortcomings:
  - CLERB investigations aren't as independent as they should be.
  - They often have to rely on evidence the SDSD provides from their own investigations.
  - Often CLERB doesn't have an opportunity to interview witnesses, specifically sworn officers and don't get an opportunity to visit the initial death scene, and the Investigators often don't get results until several months later.
  - CLERB, at one time, wasn't prioritizing in-custody deaths and, as a result, didn't investigate 57 in-custody death between 2006-2017.
  - They recommended CLERB be able to conduct independent interviews of sworn staff and for the Sheriff's Department to facilitate CLERB's ability to so.
  - CLERB needs to revise its Rules and Recommendations to prioritize in-custody deaths and also review those classified as natural, because some of these "natural" deaths may be related to a mental health/medical issue not properly attended to.
  - Recommendation was made that CLERB modify its comprehensive training manual to ensure thorough investigations.
  - Regarding the Sheriff's. Because they are elected by voters of the County, and BOS only has a certain amount of authority, their recommendations were related to the California State Legislature, which would require the Sheriff's Department to improve its procedures to have a mental health professional at intake and, as part of the booking process, identify individuals mental/medical health issues, ensure they're getting timely access to follow up care. Also, that it clarifies its policy regarding hourly safety checks to ensure individuals in their cells are alive and breathing. And, finally, require them to improve their robustness in their reviews of any future in-custody deaths—that they be documented, transparent and focused on any needed improvements to policies and procedures to limit future deaths.
  - At a State level they recommended they change regulations to raise the bar to clarify what safety checks should entail, and, for larger jails, have a mental health professional as a part of intake process, and to also increase training requirements for correctional officers and sworn staff.

Board Member Comments

- Pastor Spriggs thanked Mr. Tilden for his service and wanted clarity that between 2006 and 2017, there were 57 deaths not investigated. Mr. Tilden affirmed. There were 185 deaths during that time period, and another 18 in 2021. In terms of 2006-2017, of the 185, 57 were not reviewed. Apparently, the one year time limit had expired, as they weren't prioritizing death cases. Also, tour death cases CLERB didn't investigate because the Sheriff's Department failed to inform CLERB of their occurrence.
- Mr. Ware thanked Mr. Tilden and Ms. Sanders for the provided information. He asked if he in-custody death rates were in California and, if so, does that include every system in the State? And were the other three counties he referred to. Mr. Tilden confirmed: Alameda County Sheriff's office, Orange County Sheriff's Department, and Riverside County Sheriff's Department. He pointed out the appendix

DRAFT

to page 59, that discloses the in-custody deaths in California's 15 largest counties. The County Sheriff's Department with the most deaths in that 15-year period was Los Angeles with 421 deaths, followed by San Diego with 185. But what's different is the average daily jail population in Los Angeles 17,000 incarcerated individuals versus about 5,200 for San Diego. So, looking at an average death based on a daily population, unfortunately, the death rate in San Diego is the highest.

- Ms. Pintar thanked the Auditors for their work and requested clarification regarding Riverside's practices. Mr. Tilden confirmed Riverside actually has a mental health practitioner at intake, whose role is to specifically evaluate all individuals coming in. Ms. Pintar then asked if they're ever referred to something other than a detention facility. Mr. Tilden says the key to the evaluations is so the Department can use that information when making housing assignments, referrals for mental health care. Ms. Pintar asked if Riverside is unusual in comparison to other counties and, are they sworn staff? Mr. Tilden responded Riverside is the one that only that has someone involved at the intake. This Board of State Community Corrections, they don't require this. Without identifying the individual's health issues, you won't be able to provide proper housing assignments or give them the critical follow up care they need.
- Mr. Wilson asked of a way to do hourly checkups without waking inmates? Mr. Tilden responded it's not healthy to do so. There's more than just glancing, but taking a longer look to see if they're breathing.
- Mr. Ware regarding the term "best practice", what's stopping other agencies/counties from applying this practice and making it a mandate. Mr. Tilden believes the bill Dr. Weber is working on would require the Board on State and Community Corrections to elevate its standards. One could be requiring them to provide more specificity on how safety checks should be conducted, and also have a mental health professional involved in the evaluation.
- Ms. Pintar commented on additional recommendations involving body-scans. A lot of cases reviewed, and discussions involve intake as it relates to medical or sworn staff not recognizing someone in distress during intake and they pass away while in custody. She wonders if it would be appropriate to have SDSD come to a future meeting and walk them through the intake process.
- Ms. Kean Ayub, to Ms. Pintar's point. To Mr. Tilden, in SD an average of in-custody deaths for overdoses. If not, what is the difference in other agencies/facilities he sees that stands out that's causing such difference. Mr. Tilden can't speak to differences in overdose because the deaths are categorized in very specific buckets. 88 of the 185 deaths were natural, which is also a high number, unfortunately the data they have is not a level where they can speak to individuals who died of a drug overdose. Ms. Ayub also asked if anything in San Diego demonstrates a lack of attention to the basic overall health to those in custody. Mr. Tilden found they're not doing a good job at identifying mental and health needs.
- Mr. Ware asked, if we have access and can physically see the intake process when going on a facility tour. EO Parker confirmed. Mr. Ware also asked what has been the results of the prior reports, have they promoted change with facilities? Mr. Tilden responded one of the benefits of conducting an audit, is when they put out a report, it can shine a spotlight on problems and give opportunity to highlight needed corrections. This one's different because recommendations weren't directly issued to SDSD, primarily because they don't have a good track record in terms of implementing recommendations from others. They thought it was important to make legislative recommendations.
- Ms. Delaney discussed detention center tours/inspections. They will be looking at intake. This demonstrates the need for CLERB to be able to investigate the medical and mental health aspects.
- EO Parker discussed some of the items Mr. Tilden mentioned earlier. CLERB has put forth recommendations to address those issues, safety checks, not breaking of the stride, medical emergencies, etc. Sometimes, there's not an efficient or expeditious response. Moving forward we want to ensure, especially with Dr. Weber's bill, AB 2343, that would get this to be a standard statewide. As far as the recommendations the State Auditor made, CLERB has a 60-day report back that's due April 4. CLERB is still working with the Deputy Sheriff's Association, who have been responsive. CLERB is also working with outside counsel to get information as part of investigations and are also updating the training manual. P&P have been updated and implemented. Rules and regulations for in-custody deaths will be a priority, to include natural deaths. And, finally to look at overall trends in deaths. EO Parker also pointed out that he and Acting Sheriff Kelly Martinez, on February 14 signed an MOU, allowing CLERB to go to in-custody death scenes. Since then, he's been to three death scenes and two deputy-involved shooting scenes. The Sheriff's Department was collaborative and professional, so there is progress.

DRAFT

- Mr. Wilson responded regarding intake: we should keep in mind there are civilians in the Sheriff's Department. And, perhaps our jurisdiction should include being able to investigate them as well. EO Parker responded that CLERB has given him authority to work with County staff to work with those providing medical and mental healthcare, which includes contract employees. The San Diegans for justice Report that came out March 3, would like to expand that and would like the Board of Supervisors to expand our jurisdiction to include all personnel of the Sheriff's and Probation Department.
- Mr. Ware commented, regarding response to death scenes, does that expedite the process or extend it because you're doing a more thorough investigation. EO responded that it doesn't expedite the process. It provides a level of independence and transparency. However, they cannot complete a thorough investigation until they receive the materials from the Department.
- Ms. Wigfall commented regarding lack of knowledge of mental health issues, does this include individuals that sign a waiver to refuse medical care. Mr. Tilden responded that, although there are individuals who refuse medical care, they're talking about situations where the Sheriff's Department is not identifying the issues in the first place. Ms. Sanders added there are concerns about the number of refusals signed by sworn officers as opposed to a medical professional.
- Ms. Kenk, regarding Mental Health Officials in Riverside, do they ever put people back into a 5150, where they go to a hospital as opposed to incarceration. Ms. Sanders affirmed.

The meeting was adjourned at 7:30 p.m.

Minutes prepared by Eliza Hugee, Administrative Secretary

PAUL R. PARKER III
Executive Officer

ROBERT SPRIGGS, JR.
Secretary to the Board

DRAFT