**EXECUTIVE OFFICER**
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# County of San Diego

## CITIZENS' LAW ENFORCEMENT REVIEW BOARD

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The Citizens' Law Enforcement Review Board made the following findings in the closed session portion of its December 13, 2022, meeting held via the Zoom Platform. Minutes of the open session portion of this meeting will be available following the Review Board's review and adoption of the minutes at its next meeting. Meeting agendas, minutes, and other information about the Review Board are available upon request or at www.sdcounty.ca.gov/clerb.

**CLOSED SESSION**

a) PUBLIC EMPLOYEE DISCIPLINE/DISMISSAL/RELEASE
**Discussion & Consideration of Complaints & Reports:** Pursuant to Government Code Section 54957 to hear complaints or charges brought against Sheriff or Probation employees by a citizen (unless the employee requests a public session). Notice pursuant to Government Code Section 54957 for deliberations regarding consideration of subject officer discipline recommendation (if applicable).

| DEFINITION OF FINDINGS | |
|---|---|
| Action Justified | The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper. |
| Not Sustained | There was insufficient evidence to either prove or disprove the allegation. |
| Sustained | The evidence supports the allegation and the act or conduct was not justified. |
| Unfounded | The evidence shows that the alleged act or conduct did not occur. |
| Summary Dismissal | The Review Board lacks jurisdiction or the complaint clearly lacks merit. |

**CASES FOR SUMMARY HEARING (14)**

**ALLEGATIONS, BOARD FINDINGS & RATIONALES**

**21-069/RODRIGUEZ (DEATH)**

1. Death Investigation/In-Custody Drug-Related – On 07-20-21, Saxon Rodriguez, an incarcerated person at San Diego Central Jail, was found unresponsive by deputies during a "hard count." Despite aggressive resuscitative efforts, he was pronounced dead while at the jail. His cause of death was due to fentanyl and methamphetamine toxicity, and the manner of death was accident.

   Board Finding: Not Sustained
   Rationale: On 07-16-21, Saxon Rodriguez was arrested by Chula Vista Police Department (CVPD) officers for one charge of assault with a deadly weapon and one charge of indecent exposure. On 07-20-21, at approximately 9:59 a.m., Rodriguez was housed at the San Diego Central Jail (SDCJ) when he was found unresponsive during a "hard count." Deputies moved Rodriguez to the floor and, along with jail medical personnel, started CPR. After about 25 minutes of continuous CPR, six doses of Narcan and an automated external defibrillator (AED) being applied with no shocks advised, Rodriguez was pronounced dead via radio by a doctor from UCSD Hospital at 10:23 a.m.

   On 07-21-21, the San Diego Medical Examiner's Office conducted an autopsy, during which Rodriguez tested presumptively positive for fentanyl. Rodriguez's cause of death was subsequently determined to be combined fentanyl and methamphetamine toxicity, and the manner of death was accident.

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Title 15 and SDSD P&P mandate safety checks of all incarcerated persons via direct visualization within every 60-minute period, with no more than 60-minute lapse between said checks (see the Rationale for Allegation #3 below for further information). CLERB's investigation revealed that 65 minutes and 28 seconds elapsed between the last uneventful direct visualization by SDSD staff and the direct visualization during which he was determined to be unresponsive.

SDSD has implemented and taken measures to deter drugs from entering their detention facilities. Unfortunately, despite all interdiction efforts, there is no doubt that Rodriguez, while as an incarcerated person in the custody and under the care of the SDSD, acquired and took fentanyl and methamphetamine, which resulted in his death. In addition, it was unknown whether the five-minute and 28-second delay in mandated direct visualization of Rodriguez would have prevented his death. Despite the presence of drugs in the detention facility via unknown means in conjunction with the untimely check, there is not a preponderance of evidence that sworn staff's actions, or lack thereof, resulted in the death.

2. Misconduct/Procedure – Unidentified SDSD staff failed to "keep illicit drugs out of the jail system."

   Board Finding: Sustained
   Rationale: Rodriguez's mother, in her signed complaint, wanted to know if there were any procedural violations pertaining to "keeping illicit drugs out of the jail system." Although SDSD has implemented and taken measures to deter drugs from entering their jails, Rodriguez acquired fentanyl and methamphetamine which consequently contributed to his death. Despite all interdiction efforts, there is no doubt that Rodriguez, while as an incarcerated persons in the custody and under the care of the SDSD, acquired and took fentanyl and methamphetamine, which resulted in his death. The investigation failed to confirm how the fentanyl and methamphetamine entered the detention facility, but it clearly did. The evidence indicated that either sworn SDSD personnel and/or non-sworn SDSD personnel failed to prevent illicit drugs from entering the detention facility and that act or conduct was not justified.

3. Misconduct/Procedure – Unidentified deputies "failed to conduct timely security/safety checks."

   Board Finding: Sustained
   Rationale: According to California Code of Regulations Title 15, Section 1027.5, entitled, "Safety Checks" (emphasis bolded): Safety checks **shall be conducted at least hourly through direct visual observation of all inmates**. There **shall be no more than a 60-minute lapse between safety checks**. There shall be a written plan that includes the documentation of routine safety checks.

   According to the Policy Section of Detention Services Bureau (DSB) P&P I.64, entitled, "Safety Checks: Housing and Holding Areas of Incarcerated Persons" (emphasis bolded): **Sworn staff will conduct safety checks** of incarcerated persons, housing areas, holding areas and vacant cells **through direct visual observation** (i.e., direct personal view of the incarcerated person/area without the aid of audio/video equipment). **Safety checks of incarcerated persons consist of looking at the incarcerated persons for any obvious signs of medical distress, trauma, or criminal activity. Safety checks shall be conducted at least once within every 60-minute time period.** Safety checks of Medical Observation Beds (MOB) and in Psychiatric Stabilization Units (WPSU/PSU) shall be conducted at least once within every 30-minute time-period. The intervals of the safety checks, within the 60- or 30-minute time-period, shall vary and must be logged in the Jail Information Management System (JIMS). In addition to observing the safety and welfare of incarcerated persons, sworn staff shall also be attentive to security and maintenance issues as well as environmental factors (e.g., temperature, odors, cleanliness) while conducting safety checks.

   As indicated above, Title 15 and SDSD's policies mandate the direct visual observation of incarcerated persons with no more than a 60-minute lapse between the direct visual observations. SDSD's current practice, however, is to start safety checks within the 60-minute time-period but not necessarily to directly visualize each incarcerated person within that time-period, thus resulting in innumerable instances where incarcerated persons are not directly visually observed within statutorily mandated time-periods. SDSD considers the resulting safety checks to be completed within statute and policy. For example, if a safety

check of a module is started within 55 minutes of the last safety check start time, SDSD considers the safety checks occurring during that check as within statute and policy, even if the actual time between direct visualization of an incarcerated person is just a few minutes over 60 minutes or many minutes over 60 minutes.

CLERB's investigation revealed that 65 minutes and 28 seconds elapsed between the last uneventful direct visualization by SDSD staff and the direct visualization he was determined to be unresponsive. While it is unknown whether the five-minute and 28-second delay in mandated direct visualization of Rodriguez would have prevented his death, as it pertains to the safety of incarcerated persons and the prevention of deaths or negative physical or mental health outcomes, every second counts. This delay was in violation of SDSD policy and Title 15, however, as the current SDSD practice allows for the starting of the checks within the 60-minute period, no matter when the actual direct visualization occurs, even if that visualization is outside of the 60-minute period, a sustained finding will not be recommended against the involved deputies following the standard practice but, instead, against the SDSD itself for knowingly allowing practices that routinely violate Title 15 and its own policy and procedures. As such, the evidence indicates the conduct occurred and was not justified.

4. Misconduct/Procedure – Unidentified deputies failed to "recognize that [Rodriguez] was in medical distress."

   Board Finding: Not Sustained
   Rationale: Rodriguez's mother, in her signed complaint, wanted to know if there were any procedural violations pertaining to recognizing that Rodriguez was in medical distress. The evidence indicates that upon discovering Rodriguez unresponsive, deputies immediately summoned medical assistance and worked with on-duty medical personnel during resuscitative efforts. However, it is unclear, and unable to be determined, whether Rodriguez was "in medical distress" during previous checks, especially considering his death was the result of fentanyl and methamphetamine toxicity. As such, there was insufficient evidence to prove or disprove the allegation.

5. Misconduct/Medical (I/O) – Unidentified staff failed "to place [Rodriguez] on a heroin/opioid withdrawal medication protocol."

   Board Finding: Summary Dismissal
   Rationale: According to SDSD medical records, upon booking into SDCJ, Rodriguez indicated he had no known allergies; took no medications; did not express suicidal or homicidal ideation, attempts, or intent; had not recently used alcohol, heroin, prescription pain medications or sedatives; did not use any other illegal drugs; and had not been in a detox program or substance abuse program in the previous 90 days. Rodriguez indicated he was on no current medications. There was also no history or risk of alcohol or drug withdrawal. Based upon his medical assessment, he was medically cleared and deemed "fit to book." While all evidence indicated that Rodriguez was properly medically screened, CLERB does not have jurisdiction to investigate allegations against medical service providers working in SDSD detention facilities.

6. Misconduct/Procedure – Deputies 1 and 2, along with other responding deputies, "failed to initiate cardiopulmonary resuscitative efforts in a timely manner."

   Board Finding: Unfounded
   Rationale: According to SDSD jail surveillance video, Deputy 1 discovered Rodriguez unresponsive in his cell. Deputies 1 and 2 subsequently took immediate and appropriate action responding to Rodriguez's medical emergency. Deputies 1, 2, and numerous other deputies immediately worked with on-duty health staff and assisted with resuscitative efforts. The evidence shows that the alleged act or conduct did not occur.

**POLICY RECOMMENDATION:**

1. It is recommended that SDSD take all necessary measures to change its current practice to conform with statute and its own existing policy by mandating that every incarcerated person be directly observed by sworn staff at random intervals not to exceed 60 minutes (30 minutes for Medical Observation Beds and in Psychiatric Stabilization Units and 15 minutes for safety cells), as opposed to simply ensuring the safety checks start within the mandated time-period.

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**21-114/ESHBACH (DEATH)**

1. Death Investigation/In-Custody Medical – Richard Frederick Eshbach was incarcerated at George Bailey Detention Facility (GBDF) until transported to Scripps Mercy Hospital where he tested positive for COVID-19; Eshbach died on 11-08-21.

   Board Finding: Action Justified
   Rationale: Richard Frederick Eshbach was a 58-year-old white male who was arrested by the Oceanside Police Department on 09-17-21, for Stalking with a Protective Order in place and violation of a Court Restraining Order. He was booked into San Diego Sheriff Department (SDSD) custody and initially housed at the Vista Detention Facility (VDF). On 09-27-21, Eshbach was transferred to GBDF. On 10-19-21, a detentions deputy observed "marks" on Eshbach's body and found Eshbach to be in an altered state. Eshbach was escorted to the medical unit where he was evaluated by jail medical staff, "status post (s/p) altercation" and transferred to the hospital for further evaluation. Detentions Investigation Unit detectives conducted a thorough investigation into the alleged assault. Detectives concluded, based on all the evidence that the incident was a misdemeanor battery. The investigative findings were submitted to the District Attorney (DA); however, the DA rejected the case due to "insufficient evidence of corpus." According to Scripps Mercy Hospital medical records, Eshbach was evaluated in the trauma bay after arriving with altered mental status and reported "fall from his bunk." SDSD records produced no incident reports and/or any documented evidence that Eshbach fell out of his bunk. Following a complete assessment, hospital medical personnel found no evidence of trauma. Eshbach was febrile and subsequently tested positive for COVID-19 and found to have COVID pneumonia. According to San Diego Sheriff Department (SDSD) records, Eshbach tested negative for COVID-19 when booked into SDSD custody. Eshbach was offered the COVID-19 vaccine, however, he declined. SDSD documentation showed Eshbach was assessed frequently for COVID-19 symptoms. Eshbach's COVID test, on 10-18-21, prior to his hospitalization returned a positive result, however, results of this test were learned after his hospitalization on 10-19-21. Eshbach was admitted to the hospital and on 11-08-21, he died. The San Diego County Medical Examiner's Office (SDCMEO) conducted an external examination and determined the cause of death to be complications of COVID-19 with cirrhosis of the liver and pulmonary emphysema as contributing, and the manner of death natural. Eshbach was classified and housed properly in accordance with policy. The evidence showed that there was no violation of policy and procedure on behalf of SDSD sworn staff.

2. Misconduct/Procedure – SDSD delayed notification of Eshbach's hospitalization to family.

   Board Finding: Action Justified
   Rational: Eshbach's sister stated, "Richard was hospitalized on Sunday 10-17-21 via ambulance from 911 call from George Bailey Detention center. Family not contacted until Thursday 10-28-21. On 11-8-21 my mother received a call that he was on total life support and some family could come to the hospital." According to SDSD DSB Policy M.5 Medical Emergencies, "When an inmate is admitted to a hospital for treatment of a serious illness or injury, the watch commander shall determine if possible, whether the inmate wishes notification to the emergency contact. In situations where the wishes of the inmate cannot be determined due to the severity of the illness or injury, contact shall be made." Additionally, SDSD Medical Services Division Policy MSD.N.1, states in part, "It shall be the responsibility of each detention facility watch commander to notify the patient's next of kin, legal guardian or emergency contact of grave medical illness, life threatening injuries, hospitalization or death while in the custody of San Diego Sheriff's

Department." According to Eshbach's mother, she provided the following statement, "I was notified my son was in Mercy Hospital and had contracted COVID, while incarcerated at GBDF. I was able to speak to the doctor who was treating Richard on a daily basis." Eshbach's daughter stated it was approximately ten days after her father's hospitalization when the family was notified. Both of the above referenced policies do not identify a time frame of when notification shall be made, only that it shall be done. As such, the evidence showed that notification was made to Eshbach's family and was done so according to policy.

3. Misconduct/Medical (I/O) – SDSD neglected Eshbach's medical needs.

   Board Finding: Summary Dismissal
   Rationale: Eshbach's sister stated, "The medical examiner's report states that Richard was in altercation with another inmate and that he had fallen out of his bunk. Was Richard provided timely medical care after the incidents?" SDSD DSB Policy M.5 Medical Emergencies, states in part, "All facility staff shall be responsible for taking appropriate action in recognizing, reporting or responding to an inmate's emergency medical needs. In any situation requiring medical response, emergency medical care shall be provided with efficiency and speed without compromising security." According to jail medical records, Eshbach was "brought to medical for evaluation status post (s/p) altercation." When evaluated, Eshbach's vitals were determined abnormal and he was sent to the hospital for further evaluation. SDSD records documented that when sworn personnel recognized Eshbach was in an altered state and appeared to be in distress they immediately escorted him to the medical unit. CLERB does not have jurisdiction to investigate decisions made by medical personnel, per CLERB Rules and Regulations 4.1 titled, Citizen Complaints: Authority, which states, CLERB shall have authority to receive, review, investigate, and report on Complaints filed against peace officers or custodial officers employed by the County in the Sheriff's Department or the Probation Department. Medical Staff are non-sworn personnel over whom CLERB has no authority.

4. Misconduct/Procedure – SDSD provided "poor living conditions" at the facility.

   Board Finding: Unfounded
   Rationale: Eshbach's sister stated, "Richard had been at George Bailey for a month, he caught Covid 19 while in custody. His children told me that he described the conditions as terrible, people were sick all around him. The bathrooms were very unsanitary." In review of Eshbach's jail phone calls, he did talk about the conditions being "unsanitary, and the toilets being disgusting." On 07-07-22, I requested all maintenance records for the module housing unit where Eshbach was housed. A response was received on 07-20-22 from the facility contact and there were no maintenance requests and/or reports of malfunctioning toilets for the specified area and for the specified dates. The evidence did not corroborate the alleged conduct.

5. Misconduct/Procedure – SDSD conducted "inadequate" safety checks.

   Board Finding: Unfounded
   Rationale: Eshbach's sister stated, "I listed inadequate safety checks because it was stated in the coroner's report that he had fallen out of the bunk and was in an altered stated. It also states that Richard was in altercation with another inmate earlier in the day he was hospitalized." SDSD DSB Policy I.64 Safety Checks, states in part, "Sworn staff will conduct safety checks of inmates, housing areas, holding areas and vacant cells through direct visual observation (i.e., direct personal view of the inmate/area without the aid of audio/video equipment). Safety checks of inmates consist of looking at the inmates for any obvious signs of medical distress, trauma or criminal activity. Safety checks shall be conducted at least once within every hour (60 minute) time period." According to the JIMS Area Activity Summary Report cross referenced with jail surveillance video, safety checks were conducted timely and per policy. The evidence showed the alleged act or conduct did not occur.

**POLICY RECOMMENDATIONS:**

It is recommended that SDSD:

1. Revise Procedure Section I.A of Medical Services Division (MSD) P&P MSD.N.1, entitled, "Notification of Next of Kin/Legal Guardian" to read as follows (suggested revision bolded and underlined):

   "When a patient has sustained a serious injury, is gravely ill, or has any condition where the potential of maintaining life is questionable, the supervising nurse or designee of medical services shall, **while understanding the immediacy of notification and when reasonably possible,** notify the detention facility's watch commander."

2. To conform with the verbiage utilized in P&P MSD.N.1 above, revise Procedure Section H of Detentions Services Bureau (DSB) P&P M.5, entitled, "Medical Emergencies," to read as follows (suggested revision bolded and underlined):

   "When a person is admitted to a hospital for treatment of **a serious injury, is gravely ill, or has any condition where the potential of maintaining life is questionable**, the watch commander shall:"

3. Revise Subsection #3 of Procedure Section H of DSB P&P M.5, entitled, "Medical Emergencies," to read as follows (suggested revisions bolded and underlined):

   Subsection 3: If desired by the person, notify the emergency contact person of the person's **serious injury, grave illness, or the condition where the potential of maintaining life is questionable**.

4. Add to the most appropriate location within DSB P&P M.5, entitled, "Medical Emergencies," the following verbiage, or words to its effect:

   When an incarcerated person is admitted to a hospital for treatment of **serious injury, grave illness, or condition where the potential of maintaining life is questionable, the watch commander shall notify, or attempt to notify, the next of kin, emergency contact, or legal guardian within 12 hours.**

5. Add to the most appropriate location within DSB P&P M.5, entitled, "Medical Emergencies," the following verbiage, or words to its effect:

   All attempts to and successful notifications of **the next of kin, emergency contact, or legal guardian will be documented.**

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**21-117/TUCK**

1. False Arrest – Deputy 1 arrested Roy Eugene Tuck.

   Board Finding: Action Justified
   Rationale: According to the complainant's written statement, he reported "*The sheriff officers arrived on scene and not only after some discussions elected to arrest me, but arrest me and charge me with Domestic Violence and drop a Felony charge in my lap. I was arrested despite my wife informing all of the officers she DID NOT want me arrested period! She would not press ANY charges*." Roy was detained by San Diego Sheriff's Department deputies for suspicion of domestic violence. Sheriff deputies conducted an investigation. Roy was determined to be the aggressor. As such, he was arrested for spousal abuse with injury and was transported to jail. According to SDSD P&P Section 6.97 titled "Domestic Violence Incidents," all personnel responding to calls where the potential for domestic violence exists shall treat these calls as any other call for service where a law violation exists. A pro-arrest response and investigation of domestic violence related incidents will be handled in accordance with

Domestic Violence Reporting laws and the San Diego County Domestic Violence Protocol. The safety of domestic violence victims, whether the threat of violence is immediate or remote, should be the primary concern of the personnel, dispatchers or 911 operators. All personnel shall advise the victim to ensure their safety in any way possible. Based on the statements and injuries, Deputy 1 arrested Roy as the suspect/aggressor. Arresting Roy was in compliance with San Diego Sheriff's Department Policy & Procedure SDSD P&P Section 2.51 and California State law. The primary duty of officers, when responding to a domestic violence situation, is to enforce the laws allegedly violated and to protect the complaining party. During a domestic dispute, the victim alleged that her husband, Roy, assaulted her by choking her. The victim sustained redness to her neck. For this reason, and after conducting an initial investigation, Deputy 1 arrested Roy for violation of California Penal Code Section 273.5(a) - Spousal/Cohabitant Abuse with Injury. The evidence showed that the alleged act did occur, and it was lawful, justified and proper.

2. Misconduct/Procedure – Deputies 1 and 2 placed handcuffs on Roy's wrist that resulted in Roy sustaining injury.

   Board Finding: Not Sustained
   Rationale: In the complainant's written statement he reported deputies applied handcuffs that were too tight on his wrist; that the harsh handling had exacerbated his medical condition and caused injury. The complainant reported, *"I have been disabled and on Social Security Disability for several years now. I immediately started telling both officers (which should all be on both of their body camera footages) that I had a physical condition and if I was to be arrested to please use extra large handcuffs or multiple extra large cuffs. I begged the two arresting officers and pleaded with them for several minutes to please use zip ties or if they had to hand cuff me for transport since I am fully cooperative to please secure my hands in front of my torso or on my lap. I even told the officers they could shackle my legs. I am not running anywhere or being non-conforming in any fashion. The two arresting officers went on to TOTALLY ignore my numerous plea's for special consideration due to my age and present physical restrictions/impairments, and went on to use the normal run of the mill standard size hand cuffs to secure me. ….and the arresting officer who applied to standard sized cuffs to my wrists over synched them both down [which caused me immediate extreme nerve damage, extreme joint discomfort coupled with hours, and now days and weeks of severe pain. The same two officers totally IGNORED my constant and numerous pleas said in extreme pain to please stop and either loosen my cuffs or use a larger size or multiple cuffs or zip ties to my wrists…I mentioned numerous times I could not feel my hands especially my right hand, and that both of my shoulders felt like they were popping out of their sockets] went on to commit "police brutality" I was badly hurt and the entire time in extreme passing out type of pain at that moment in time. Both of my wrists were completely numb, I could not feel my right hand, and both shoulders felt like they were popped out of socket, I endured unduly inflicted extreme pain as a direct result c1f the arresting officers actions or in-actions. I was in extreme pain now, [or maybe they did'nt maybe it was time to book me into jail who knows why] when my right cuff in particular was removed I was in total shock, what was in front of my was shocking, my entire right wrist was bleeding and indented about ½ an inch all the way around my wrist and super dark black/purple/red in color. The two arresting officers and I all stood there for a silent few seconds "dumfounded' all of us in shock, maybe not me as much as the two arresting officers because I had been warning them. …choose to inflict more pain to a arrested persons experience for hours. they both elected to totally ignore the gross painful injuries they both intentionally inflicted on me for several hours…. totally ignore my numerous plea's to stop the injuries and stop compounding them all the while causing me extreme pain, refused all of my please for ANY medical assistance or attention to my gross bleeding intentionally inflicted cuff wounds over a period of hours. The [hospital Emergency Department physician] who has diagnosed my injury and has referred me to another specialist ["12 visits] for "Wartenberg's Syndrome" inflicted by the arresting officers."* Four SDSD Body Worn Camera (BWC) recordings were viewed. In the BWC recordings, two deputies were observed to place handcuffs on Roy. Two sets of handcuffs were used as the complainant was a large-framed man. In Deputy 1's arrest report he noted, "*Once deputies arrived, Roy was located sleeping next to the property clubhouse pool and was detained in handcuffs*." Deputy 1 also noted that he "*detained Roy and placed handcuffs on his wrists and escorted him to Deputy 2's patrol vehicle. Two sets of handcuffs had to be used because of Roy's large size (5'11"/283lbs)."* Neither Deputies 1 nor 2 were

observed to engage the double locking mechanism after handcuffs were placed on Roy. After a few minutes of having the handcuffs placed on him, Roy was seen and heard to protest having handcuffs on and the placement of the handcuffs; however, the handcuffs were not removed, repositioned, or checked to see if they were causing injury. According to the California Commission on Peace Officer Standard and Training (POST), the most common restraint device available to peace officers is handcuffs. The standard recommends that handcuffs should be properly adjusted. Too tight may cause reduced circulation or nerve damage. Handcuffs **should** be double locked when tactically safe. Double locking reduces the possibility of inflicting injury from handcuffs tightening further on the prisoner's wrists. The principal reason for handcuffing an arrestee is to maintain control of the individual. The arresting deputy is responsible for the safety and well-being of the arrestee. It is the deputies' duty to keep the arrestee safe from harm and to prevent their escape. Deputies shall apply handcuffs tightly enough to control the detainee/arrestee and **should** double lock the handcuffs as soon as practical. To prevent over-tightening the handcuffs, deputies are taught to inserting a fingertip between the handcuffs and the prisoner's wrist to ensure sufficient space and reduce the risk of injury. Persons taken into custody shall be handcuffed. Persons shall be handcuffed with their hands behind them and with the backs of the hands together, unless this technique would hamper an investigation, or the prisoner has a physical condition or injury that precludes this technique. Handcuffs are double-locked to prevent tightening, which may cause undue discomfort or injury to the hands or wrists. Medical records were obtained from Palomar Medical Center and from the jail's medical division. Medical records confirmed that Roy sustained injury from the handcuffs. To be clear, not engaging the double locking mechanism is not a violation of policy; however, not doing so would by contrary to his training and subsequently, could injury the arrestee. Deputy 1 provided information during the course of CLERB's investigation that was considered in arriving at the recommended finding, however, it is privileged per the Peace Officer Bill of Rights (POBR) and cannot be publicly disclosed. There was insufficient evidence to either prove or disprove the allegation.

3. Misconduct/Procedure – Deputy 1 and 2 denied the complainant medical attention.

   Board Finding: Unfounded
   Rationale: In the complainant's written statement, he reported *"…all the while refusing me ANY medical attention or acknowledging ANY of my numerous plea's for medical assistance or ANY help. During the entire night I told both officers I was also very worried about blood clots as a result of my wrists being restricted, and now later enduring extreme nerve damage as a direct result of the arresting officers actions or in-actions during my entire arrest my civil rights were violated the entire nightmarish night. I could also see it on both of their faces that they had both just made a major procedural fuck up and were in "clean up mode" already. They totally ignored my plea's to go to nearby Tri City hospital. And went on to totally ignore my plea's to go to the jail's medical facility. The two officers looked dumbfounded when I held my right wrist that had just been uncuffed closer to all of our faces and I said" hey 'this is terrible, it looks gross and I am bleeding" "I need to go to the hospital." The two arresting officers went on to continue to totally ignore my numerous verbal pleas' to take me to Tri City Emergency room directly across the street, and to take me to the jails medical ward for the proper medical attention and to document my injury[s]. The two arresting officers summoned the jail house nurse [ after I believe they pulled her aside and coached her on what to do or not do for me]"* After being processed at the Vista Patrol Station, Roy was transported to the Vista Detention Facility. According to jail medical records, the complainant was booked into jail on 11-12-21, at 1:55am. Upon his arrival to jail, he was seen by the jail's Intake Medical staff. His vitals were taken, and he was found fit for jail. It was medical opinion that Roy did not require hospitalization. Deputy 1 made the health staff aware of Roy's medical aliments, his current complaints of pain, and his medical history. Roy was scheduled for jail medical sick call with a medical doctor to follow-up with his aliments and co-morbidities, but those appointments were cancelled upon his release from jail. Roy was released from jail on 11-12-21, at 7:37am. According to SDSD P&P Section 2.48 entitled, "Treatment of Persons in Custody," employees shall not mistreat, nor abuse physically or verbally, persons who are in their custody. Employees shall handle such persons in accordance with law and established Departmental procedures. The evidence showed that the alleged act did not occur.

4. Misconduct/Medical – Jail nursing staff failed to provide medical care to the complainant.

Board Finding: Summary Dismissal
Rationale: In the complainant's written statement, he advised "*…the jail house nurse came over and just applied a large bandage to the bloody nerve damages right wrist and merely walked away, the nurse she also ignored my numerous verbal plea's for medical attention and to be seen by the local emergency room or the jail medical facility. I was again being punished physically, ignored and denied my civil liberties."* Upon his arrival to jail, Roy was seen and treated by the jail's Intake Medical staff. He was found fit for jail and did not require hospitalization or a higher level of care. In this allegation, there was no prima facie showing of misconduct against sworn personnel. The allegations against the Medical/Health Services staff are summarily dismissed, as CLERB does not have any jurisdiction against the Medical Services Division. Health Services staff members are not sworn staff. The CLERB Review Board lacks jurisdiction as it cannot take any action in respect to complaint against non-sworn SDSD employees, per CLERB Rules and Regulations 4.1.2.

5. Misconduct/Procedure – Unidentified Internal Affairs Division deputies failed to respond to the complainant's complaint.

   Board Finding: Unfounded
   Rationale: In Roy's written statement to CLERB, he alleged that unidentified deputies with the SDSD Internal Affairs Division failed to investigate his complaint against Deputy 1 and the injuries he sustained. The complainant reported, *"I filed an incident report with the San Diego Sheriffs Internal Affairs Department on November 12th the following day after my felony arrest, and I filed a follow up second officer complaint today November 26th after not getting any answer to my first complaint. I am really starting to feel like I am being totally ignored by the San Diego Sheriffs Internal Affairs people."* The SDSD Internal Affairs Unit has the primary responsibility for the investigation of all complaints. The Internal Affairs Lieutenant will make the determination where the complaint will be investigated. According to a CLERB's liaison with the SDSD Department of Inspectional Services, the complainant had filed a complaint with the SDSD Internal Affairs division. CLERB's liaison confirmed that a preliminary investigation was performed; however, due to California's Police Officer's Bill of Rights, the details of the investigation were not disclosed to CLERB. In a later telephonic conversation with Roy, it was learned that staff members from the SDSD Internal Affair's division did eventually contact Roy. The complaint was closed, via written correspondence, with no administrative investigation performed, as the allegation was found not have been a violation of Sheriff's policy, nor was the allegation a violation of the law. The letter advised that a cursory investigation was initiated, and no policy or criminal law violation was not found upon receipt of the initial complaint. The evidence showed that the alleged act or conduct did not occur.

## POLICY RECOMMENDATION

1. It is recommended that the SDSD implement a policy that provides guidelines for handcuffing. These guidelines should cover, at minimum, such topics as the proper placement of handcuffs; checking to ensure the handcuffs are not so tight as to cause injury, and mandatory engaging of the double-locking function when tactically safe. A comprehensive handcuffing policy should also provide guidelines covering the documentation of injuries and/or complaints of pain allegedly due to handcuffs and the provision of medical treatment to prisoners claiming said injuries.

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## 22-006/ISSAC (DEATH)

1. Death Investigation/Suicide (Deputy Present) – On 01-21-22, San Diego Sheriff's Department (SDSD) deputies were dispatched to the shooting of a male in Santee in which the suspect, Daniel Isaac, drove a vehicle from the scene. Deputies conducted a traffic stop on the vehicle and subsequently found Isaac inside of it with a self-inflicted gunshot wound of the head. Deputies forced entry to the vehicle, removed Isaac from it, and initiated cardiopulmonary resuscitation. Medics responded and, despite continued aggressive resuscitative efforts, Isaac was pronounced dead at the scene. The cause of death was gunshot wound of the head and the manner of death was suicide.

Board Finding: Action Justified
Rationale: While expeditiously responding to the original shooting scene, deputies located Isaac's vehicle and conducted a traffic stop in a nearby cul-de-sac. Isaac apparently shot himself in the head almost immediately after stopping, as deputies neither heard a gunshot nor saw movement inside of the vehicle. Isaac never responded to the deputies' numerous verbal commands and was subsequently found sitting unresponsive in the driver's seat. Deputies immediately initiated life-saving efforts. Unfortunately, there was no time to activate the Special Enforcement Detail or a Crisis Negotiation Team. There was no evidence to support an allegation of procedural violation, misconduct, or negligence on the part of Sheriff's Department sworn personnel.

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**22-015/LOPEZ**

1. Excessive Force – Deputies 1 and 2 purposefully struck the complainant with the door of a patrol vehicle.

   Board Finding: Unfounded
   Rationale: In the complainant's written statement, he reported, "*In April 10, 2021, I was riding my bike across N Santa Fe Vista towards Washington St. I noticed a vehicle in the middle lane with its lights off as soon as I passed next to it,* [Deputy 1] *opened his driver door and struck me causing me to flip off my bycicle [bicycle]…"* Contrary to Lopez's statement, in Deputy 1 and 2's written report, it was stated that Lopez "sideswiped" Deputy 1's patrol vehicle as he attempted to evade the deputies. According to the State of California Traffic Collison Report, Lopez's arrest report, coupled with the numerous deputies' Officer Reports, Deputy 2 attempted to conduct a traffic enforcement stop on Lopez. Deputy 1 attempted to assist Deputy 2 in the pursuit and pulled his marked patrol vehicle into a left turn and activated his overhead emergency lights. As Deputy 1 opened his driver door and attempted to exit his vehicle, Lopez attempted to ride his bicycle between the driver's side of the patrol vehicle and the raised concrete median/fence. Lopez's left bicycle handlebar sideswiped the open driver door of the patrol vehicle, which caused Lopez to lose control of his bicycle and crash into the raised concrete median/fence. According to Lopez's statement, Deputy 1 [purposely] struck him as he rode his bike passed his patrol vehicle. As a result of the accident, Lopez sustained minor injuries from the collision, but he immediately got back onto his bicycle and again fled the scene, continuing to evade deputies. Body Worn Camera (BWC) recordings related to the incident were reviewed but did not capture the collision of Lopez's bicycle and the Sheriff's patrol vehicle. The complainant's recount of events was clearly without merit, and he lacked credibility. There was no prima facie showing of misconduct. The evidence showed that the alleged act or conduct did not occur.

2. Excessive Force – Deputies 1-3 used forced to subdue Lopez.

   Board Finding: Action Justified
   Rationale: In the complainant's written statement, he advised, "…*as I am checking my injuries he pulls up shortly after Deputy 3 joins him, they forced me to the ground, handcuffed me and began to beat me. Striking me on the head and face with their knees."* According to Deputy 2's arrest report, he reported that during his apprehension, Lopez refused to comply with deputies' instructions to be handcuffed. Deputy 2 noticed that Lopez's right hand was underneath his body and he believed Lopez may have been trying to access a concealed weapon. As viewed in the deputies' Body Worn Camera (BWC) recordings, the deputies attempted to handcuff Lopez, Lopez began flailing his body and rolled onto his side. Lopez actively resisted arrest and attempted to free himself from the deputies' control. Deputy 2 used his left knee to strike Lopez in his left shoulder/bicep. Deputy 2 reported that had he not delivered the knee strike, Lopez would have continued to flail his body and he may have been able to escape their control and flee the scene. Deputy 2's use of force coincided with the actions observed in the BWC recordings. Deputies were able to handcuff Lopez without further incident. In review of evidence in this case, which included numerous BWC recordings, photographs, reports, and statements, the force used against Lopez was necessary, appropriate, effective, and reasonable for the circumstances at the time in gaining compliance. During the incident, Lopez exhibited active and passive resistance towards the

deputies. In response, Deputy 2 executed physical force control techniques. The actions executed by the deputies was in accordance with SDSD Policies and Procedures. There was no evidence to support an allegation of procedural violation, misconduct, or negligence on the part of Sheriff's Department sworn personnel. The deputies who responded to the use of force acted within policy and procedure and law. The evidence showed that the alleged act or conduct did occur and was lawful, justified and proper.

3. Misconduct/Procedure - Deputy 3 refused to administer a breathalyzer on Lopez.

   Board Finding: Unfounded
   Rationale: After his detention, and in protest of possibly going to jail, Lopez informed deputies that he would take a breathalyzer; however, the deputies refused to administer the test to him. In the complainant's written statement, he reported, "*I took and passed a field test. Dep. 3* [Deputy 3] *then told me I am going to jail for refusing the breathalyzer, I told him fine I'll take it if that's what it took for me not to go to jail he said it was too late."* According to Deputy 2's report, Lopez displayed several objective signs and symptoms of alcohol intoxication. Deputy 2 noted that Lopez's eyes were watery and bloodshot, his speech was slurred, and he had the odor of an alcoholic beverage emitting from his breath and person while speaking. With Lopez seated on the sidewalk, Deputy 2 conducted a full Horizontal Gaze Nystagmus bounce test. Deputy 2 noted that Lopez lacked smooth eye flow and noted nystagmus bounce when he looked left and right. Based on his objective signs/symptoms of alcohol intoxication Deputy 2 suspected Lopez was operating his bicycle while under the influence of an alcoholic beverage. As such, Deputy 2 charged Lopez with cycling while under the influence of drugs and/or alcohol. According to Deputy 2's written report, prior to leaving the scene, Lopez requested to take a breathalyzer test to prove his sobriety. Lopez was transported to the Vista Patrol Station where Deputy 2 opted for a chemical sample. Lopez refused to submit a chemical sample. The weight of the breathalyzer test evidence is presumptive of alcohol influence, not conclusive. Deputy 2's other evidence, such as testimony about Lopez's appearance, behavior and speech, for example, may be sufficient to support the arrest in the absence of a breathalyzer test. Relatively speaking, deputies dealing with impaired driving suspects must rely primarily on their own powers of detection to determine whether an arrest should be made. As in Lopez's case, drivers and cyclist may refuse the breathalyzer test after they have been arrested. As such, then the arrest case will depend strictly upon the deputy's observations and testimony. The evidence shows that the alleged act or conduct did not occur.

4. False Arrest - Deputy 2 arrested the complainant.

   Board Finding: Action Justified
   Rationale: In the complainant's written statement, he stated, "*I then was arrested for false charges to hide their misconduct."* According to Deputy 2's arrest report, Lopez was observed to ride his bicycle across a six-lane roadway against a solid red traffic signal, narrowly avoiding oncoming traffic. When Deputy 2 attempted to approach Lopez, Deputy 2 claimed that Lopez purposely shined a high-powered LED flashlight into his eyes and rode off. Deputy 2 attempted to conduct a traffic enforcement stop, but Lopez fled on his bike. Lopez refused to yield and rode his bike in the wrong direction. While doing so, Lopez sideswiped a stopped Sheriff's patrol vehicle. The collision caused Lopez to crash into a raised concrete median and fence. After colliding with the vehicle, Lopez got back on his bicycle and continued to evade deputies before he stopped. Lopez was placed under arrest for violation of numerous traffic violations and criminal activity. He was transported to the Vista Detention Facility where he was booked into custody. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

5. Misconduct/Medical – Hospital medical staff failed to give the complainant "proper care."

   Board Finding: Summary Dismissal
   Rationale: In the complainant's written statement, he stated, "*I was taken to the hospital, where I did not even receive proper care due to Deputy 3 interrupting me as I spoke to the nurse*." The allegations against the hospital staff are summarily dismissed, as CLERB does not have any jurisdiction against hospital staff. Hospital staff members are not sworn staff. The CLERB Review Board lacks jurisdiction as

it cannot take any action in respect to complaint against non-sworn SDSD employees, per CLERB Rules and Regulations 4.1.2. The Review Board lacks jurisdiction, or the complaint clearly lacks merit.

6. Misconduct/Discourtesy - Deputy 3 interrupted the complainant when he addressed the hospital medical staff.

   Board Finding: Not Sustained
   Rationale: In the complainant's written statement, he advised, "*I was taken to the hospital, where I did not even receive proper care due to Deputy 3 interrupting me as I spoke to the nurse*." BWC recordings of Lopez's hospitalization were viewed. The BWC recordings did not capture Lopez's entire hospitalization, but intermittence episodes of his hospitalization. In the recordings, Deputy 3 was not observed to interrupt Lopez when he addressed hospital staff. Absent information provided by an independent witness to the incident or additional video or audio recordings of the interaction, there was insufficient evidence to prove or disprove the allegation.

7. False Arrest: Deputy 2 arrested the complainant.

   Board Finding: Action Justified
   Rationale: In the complainant's written statement, he reported, "*I then was arrested the very next day. I was pulled over by Deputy 2 and booked into VDF for another false charge. I was able to bail out. …..“pulled over by Deputy 2 and booked into VDF for another false charge."* According to a SDSD Crime/Incident Report, on 11-07-21, a deputy was dispatched to investigate a restraining order violation. Lopez was a repeat violator of his brother's restraining order. Lopez violated a served restraining order by arriving at the home of his brother and disturbing his peace. Lopez was prohibited from contacting directly or indirectly in any way and must not disturb the peace. Lopez was in violation of domestic relations court order. Additionally, Lopez also had an active felony warrant for his arrest. According to Deputy 2's written report, he explained that less than 24 hours after he arrested Lopez, he arrested Lopez a second time when Lopez was found to have violated a valid temporary restraining order by going to his brother's residence. As such, Lopez was arrested. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

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**22-030/TU**

1. Use of Force Resulting in Great Bodily Injury – On 02-27-22, Deputies 1-3 used force to subdue and handcuff Incarcerated Person, Tu Ngoc Tu.

   Board Finding: Action Justified
   Rationale: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On the evening of 02-27-22, deputies assigned to the George Bailey Detention Facility (GBDF) House 2 positions were preparing the module for razor distribution. Incarcerated people with a razor restriction were being escorted out of the module. According to the written reports, Tu appeared upset about having to leave the module. In the jail surveillance video recording, deputies escorted Tu and seven other inmates out of the module, through a common area hallway, up a flight of stairs, and into the Visit Area where they were to wait while razors were in the module. In Deputy 1's report, he claimed that after entering the stairwell, before he could give Tu verbal commands to face away from him, Tu took a fighting stance with both his fists raised and clenched. Tu was within arm's reach of Deputy 1. Deputy 1 reported that he feared Tu was going to strike him. To prevent Tu from striking him, a use of force ensured. Deputies 2 and 3 assisted in the use of force. There were no jail surveillance cameras in the stairwell. As such, the use of force was not captured by any of the jail surveillance videos. The force Deputy 1 used was sufficient in preventing Tu from striking him. Deputy 1 explained that had he not used force to overcome Tu's resistance and his efforts to hit him, Tu could have assaulted him and caused injury. Tu was immediately escorted to the jail's medical facility. He was subsequently transported to a local hospital where he received treatment. After his examination at the hospital, Tu was found to have sustained swelling to his right eye, a laceration under his right eye,

and a right orbital fracture. At the time of this investigation, Tu was no longer in custody and was not available for a statement. In review of this case, there was no evidence to support an allegation of procedural violation, misconduct, or negligence on the part of Sheriff's Department sworn personnel.

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**22-046/RODRIGUEZ**

1. Misconduct/Procedure – Unidentified San Diego Sheriff's Department (SDSD) deputies assigned "tank captains" on 01-27-22.

   Board Finding: Unfounded
   Rationale: The complainant, Pedro Rodriguez alleged, "The petitioner filed grievance #224000163 against sheriff's policy of assigning tank captains which violates CA Penal Code 4019.5 forbidding 'Kangaroo Courts.'" According to a Grievance Response dated 01-29-22 by SDSD staff, SDSD has no policy which assigns "tank captains." Further, in the Grievance Response, Rodriguez was advised to notify deputies of any safety concerns in his current housing area. At this juncture, there is no credible evidence showing SDSD has policies in place which promote "Kangaroo Courts" or assigns "tank captains." The evidence showed that the alleged act or conduct did not occur.

2. Misconduct/Procedure – Deputy 1 moved Rodriguez from his housing assignment on 01-29-22.

   Board Finding: Action Justified
   Rationale: Rodriguez alleged, "On January 29, 2022 after filing grievance… co-tank captains… (incarcerated persons) directed sheriff's (Deputy 1) to move this disabled petitioner… without cause." SDSD documentation does not show Rodriguez had his housing assignment changed on 01-29-22. However, an SDSD incident report dated 01-31-22 by Deputy 1 indicated Rodriguez's room assignment was changed on that date. The Incident Report stated Rodriguez moved housing assignments after he notified deputies he feared for his safety and may be assaulted by other incarcerated persons. SDSD Detention Services Bureau (DSB) policy section R.1, Incarcerated Person Classification, regarding reclassification states, "Any employee who receives information that could change an incarcerated person's classification code and/or housing assignment has the responsibility of advising a JPMU deputy. The JPMU deputy will evaluate the information to determine whether it requires the incarcerated person to be reclassified." Given Rodriguez expressed concerns about being assaulted, it appears the deputy's actions in changing Rodriguez's room assignment were appropriate. Additionally, CCTV footage was received from George Bailey Detention Facility (GBDF) showing what appears to be Rodriguez being moved from his original housing assignment on 01-31-22. The CCTV footage depicted a deputy walking to Rodriguez's housing area and walking out of the housing area with Rodriguez. The Deputy is seen on camera the entire time he is walking with Rodriguez. No force is observed being used to escort Rodriguez. The date and time of the CCTV footage corresponds with the date and time indicated in Deputy 1's incident report. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

3. Excessive Force – Deputy 1 placed Rodriguez into a "arm lock" on 01-29-22.

   Board Finding: Unfounded
   Rationale: Rodriguez alleged, "(Deputy 1) on camera arm locked the petitioner… repeating 'I'll break your arm…' (Deputy 1) injured the petitioners knees, back, ankles and shoulder." See Rationale #2. SDSD documents showed no use of force or injury occurred related to Rodriguez's change of housing. The evidence shows that the alleged act or conduct did not occur.

4. Misconduct/Intimidation – Deputy 1 threatened to use force on Rodriguez on 01-29-22.

   Board Finding: Unfounded
   Rationale: Rodriguez alleged, "(Deputy 1) stated, '(You're) going upstairs or I will break your arm.'" As stated in Rationale #2, Rodriguez did not have his housing assignment changed on 01-29-22. SDSD

documentation showed Rodriguez's housing assignment was changed on 01-31-22. No use of force incident was documented as it related to the housing assignment change on 01-31-22. All the documentation and CCTV footage reviewed indicated this was a voluntary change of housing based upon the statements and request of Rodriguez. It would be unreasonable to believe Deputy 1 threatened to use force when the incident report written by Deputy 1 and CCTV footage indicated the change was voluntary. The evidence shows that the alleged act or conduct did not occur.

5. Misconduct/Procedure– Unidentified staff "refused" to medically treat Rodriguez's injuries following a use of force.

   Board Finding: Unfounded
   Rationale: Rodriguez alleged, "(Deputy 1) injured the petitioners knees, back, ankles and shoulder… The petitioner is injured and the San Diego Sheriff's Dept refuse to treat the petitioner for his injuries…" See Rationale #2. SDSD documents showed no use of force or injury occurred related to Rodriguez's change of housing. Further, medical records made no indication of an injury occurring on 01-31-22. The evidence shows that the alleged act or conduct did not occur.

6. Misconduct/Procedure – Unidentified staff denied Rodriguez's access to the "law library."

   Board Finding: Summary Dismissal
   Rationale: Rodriguez alleged, "Because of denial of access to the law library the petitioner is unable to learn the law to present his claims." DSB policy T.1, Correctional Counseling Program, states, "(Correctional Counselor's) shall provide reasonable assistance to incarcerated persons who are representing themselves in propria persona (Pro Per) in a current criminal case or an action challenging the conditions of their confinement, and who have been granted Pro Per status by the court. 'Reasonable assistance' consists of supporting an incarcerated person on how to operate the electronic research kiosks and how to formulate queries for such research. CC's shall not conduct research for the incarcerated person, nor suggest topics of research, nor give legal advice." CLERB Rules & Regulations, Section 4: Authority, Jurisdiction, Duties and responsibilities of CLERB, subsection 4.1, Complaints: Authority, states, "… CLERB shall have authority to receive, review, investigate, and report on complaints filed against peace officers or custodial officers employed by the County in the Sheriff's Department or the Probation Department…" Rodriguez did not identify specific staff in this allegation. Further, non-sworn staff are tasked with providing assistance with legal matters. The Review Board lacks jurisdiction, or the complaint clearly lacks merit.

7. Misconduct/Procedure – Unidentified staff "delayed" Rodriguez's mail.

   Board Finding: Unfounded
   Rationale: Rodriguez alleged, "The petitioners mail is being delayed up to 60 days." DSB policy P.3, Incarcerated Person Mail, provided guidance as it relates to the processing of incarcerated person's mail. Legal Mail shall be opened and inspected for contraband in the presence of the individual. All other mail is screened for contraband and information regarding facility security." It appeared Rodriguez's mail was not being delayed based on his communication via mail to CLERB and CLERB's communication via mail to Rodriguez. At this juncture there is no credible evidence indicating Rodriguez's mail was unnecessarily delayed. Further, Rodriguez did not identify specific staff in this allegation. The evidence shows that the alleged act or conduct did not occur.

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**22-055/TURNER**

1. Misconduct/Procedure – The San Diego Police Department arrested Turner on 02-16-22 and placed him in "overly tight" handcuffs.

   Board Finding: Summary Dismissal
   Rationale: Turner alleged, "I was arrested on (02-16-22) and placed in overly tight handcuffs…"

According to booking records, Turner was arrested on 02-16-22 by San Diego Police Department. CLERB Rules & Regulations, Section 4: Authority, Jurisdiction, Duties and responsibilities of CLERB, subsection 4.1, Complaints: Authority, states, "… CLERB shall have authority to receive, review, investigate, and report on Complaints filed against peace officers or custodial officers employed by the County in the Sheriff's Department or the Probation Department…" In this instance, the San Diego Police Department was the arresting agency. The Review Board lacks jurisdiction.

2. Misconduct/Procedure – Unidentified staff placed Turner in a room with no water or restroom on 02-16-22.

   Board Finding: Not sustained
   Rationale: Turner alleged, "On (02-16-22) I was also placed in the 2nd floor in the medical interview room with no water or restroom for 12 hours." SDSD Detention Services Bureau Policies and Procedures (DSB P&P) Section I.59, Access to Drinking Water, dated 07-06-20, stated, "As such, toilets, wash basins and drinking fountains must be provided in temporary holding cells, staging cells, sobering cells, single-occupancy cells, double-occupancy cells, dormitories, etc. There may be instances that necessitate shutting off water to such fixtures… In all instances, Sheriff's staff will be observant, make necessary notifications and maintain documentation in the Jail Information Management System (JIMS) on an Inmate Status Report (ISR)." Further, DSB P&P Section J.8, Contraband Watch, stated, "Inmates suspected of concealing contraband (e.g., foreign substances, instruments, drugs/narcotics) within their body and determined by health staff as non-life threatening to the inmate will be placed on Contraband Watch (CW)… A JIMS Incident Report will be written for each inmate placed on CW." A review of Turner's in-custody records and medical records showed no indication that Turner would have been placed into a cell without access to a toilet or drinking water. However, there is also a lack of record which showed exactly what cell turner was placed into while pending classification at intake. This does not indicate misconduct, given the policies stated above not requiring documentation unless as specified. However, given Turner's allegation that he was placed in a holding cell without drinking water or a toilet, and the lack of information about what holding cell turner was placed into, there is insufficient evidence to either prove or disprove the allegation.

3. Misconduct/Procedure – Unidentified staff placed "leg chains" on Turner's injured legs on 02-17-22 and 03-01-22.

   Board Finding: Action justified
   Rationale: Turner alleged, "I was moved on (02-17-22) to the 4th floor in a wheelchair in great pain. I have a steel plate in my leg. Leg chains were placed on my legs… On (03-01-22) my right leg was (placed) in overly tight leg chains that caused major pain and injury." SDSD records showed on 02-17-22, Turner was medically cleared for housing and classified with a green wristband. SDSD DSB P&P Section I.47, Inmate Identification Wristbands and Clothing, dated 12-30-20, defined green wristbands as, "Inmates deemed to present an escape risk, assaultive behavior, or having threatened to assault staff… Inmates with special conditions, a hazard of escape risk and/or a history of assaultive behavior will be given a green wristband." Further, SDCJ Green Sheet Section I.51.C.2, Inmate Movements – Orange and Green Band Inmate Movement, stated, "All mainline green band inmates moving off of the housing area will be moved in waist and leg chains, with an escort of a minimum of two (2) deputies…" Given the policy, and that Turner was moving to new housing, it appeared the action of placing Turner in "leg chains" is not misconduct, but rather an action as required under current policy. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

4. Misconduct/Procedure – Unidentified staff placed Turner into a cell with two other incarcerated persons.

   Board Finding: Action Justified
   Rationale: Turner alleged, "I am now in a cell… with 2 other persons that is a violation of the Title 24. I am still in a wheelchair. The maximum capacity for this cell is 2 inmates." It should be noted, San Diego Central Jail has triple occupancy cells. Further, an incarcerated person assigned a wheelchair could be appropriately housed in a triple occupancy cell based on current SDSD policy. San Diego Central Jail

Green Sheet M.39.C.1, Disabled Inmates – Usage of Lower Bunks Lower Tier, stated "A lower bunk on the three tier bunk beds on the 8th Floor and all other cells with three bunks will be satisfied by assignment to either the middle or lower bunk." In this instance, Turner was appropriately classified based on a review of current SDSD policy. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

5. Misconduct/Medical – Medical staff improperly removed Turner's cast stiches.

   Board Finding: Summary Dismissal
   Rationale: Turner alleged, "My case and stiches were removed without orthopedic doctors order (at) SDCJ." CLERB Rules & Regulations, Section 4: Authority, Jurisdiction, Duties and responsibilities of CLERB, subsection 4.1, Complaints: Authority, states, "… CLERB shall have authority to receive, review, investigate, and report on Complaints filed against peace officers or custodial officers employed by the County in the Sheriff's Department or the Probation Department…" CLERB does not have authority to investigate allegations of misconduct related to medical staff. The Review Board lacks jurisdiction.

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**22-068/FROM**

1. False Arrest – The City of Escondido Police Department falsely arrested From on 05-19-22.

   Board Finding: Summary Dismissal
   Rationale: From alleged, "… police officers (2) requested me to exit… requesting (I.D)… and ordered fingerprinting. I complied because my fingerprints come back clear… An hour or so of looking… they arrested me." SDSD booking records indicated From was arrested by the City of Escondido Police Department. CLERB Rules & Regulations, Section 4: Authority, Jurisdiction, Duties and responsibilities of CLERB, subsection 4.1, Complaints: Authority, states, "… CLERB shall have authority to receive, review, investigate, and report on Complaints filed against peace officers or custodial officers employed by the County in the Sheriff's Department or the Probation Department…" This complaint is submitted for summary dismissal per CLERB R&R Section 15: Summary Dismissal, which states, in part, Summary Dismissal may be appropriate in the following circumstances: CLERB does not have jurisdiction over the subject matter of the complaint.

2. Misconduct/Procedure – Unidentified staff did not assist From in using phones while at Vista Detention Facility (VDF).

   Board Finding: Summary Dismissal
   Rationale: From alleged, "Pin # needed to use phones does not work! Numerous grievances addressing (phones)… only negative results… Plenty of 'plausible excuses' that change with each deputy." From's allegation that he was unable to use phones while at VDF is unrelated to staff conduct. Further, based on call logs received from SDSD, it appeared From attempted numerous calls while in custody and that the calls were incomplete. See Rationale #1.

3. Misconduct/Procedure – Parole did not provide documentation to From about his charges

   Board Finding: Summary Dismissal
   Rationale: From alleged, "Never served anything, as required by protocol (and) law, by (Parole Agents), yet brought to S.D Court… last on (06-16-22), (without) any document(s) for me." From alleged misconduct by Parole Agents, however, it should be noted, documentation received by SDSD indicated From was provided information about his charges on at least two separate occasions. See Rationale #1.

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**22-072/MANRIQUEZ**

1. Use of Force Resulting in Great Bodily Injury – Deputy 1 deployed his Sheriff's canine on Alejandro

Manriquez, which resulted in Manriquez sustaining dog bites.

Board Finding: Action Justified
Rationale: On 05-23-22, Alejandro Manriquez led deputies on a high-speed pursuit after he was witnessed to run a stop sign and drive a vehicle with tinted windows. The vehicle pursuit ended when SDSD deployed a tire deflation device. Manriquez attempted to evade deputies by exiting his vehicle and fleeing on foot, but a Sheriff's Canine Unit was deployed. Manriquez was seen clutching a bag and deputies were unsure if he was armed. Manriquez continuously ignored deputy commands to stop the vehicle, stop running, and to come out from hiding. Deputy 1 issued a final warning to come out or he will be bit, but Manriquez continued to hide. The canine successfully apprehended Manriquez, and a use of force ensued. As a result, Manriquez sustained dog bites on his lower leg. During the encounter, Manriquez struck the canine in the face twice. Manriquez was transported to Palomar Medical Center (PMC) where he was treated with sixteen staples and eighteen stitches and then released to Vista Detention Facility (VDF). Manriquez was booked at Vista Detention Facility (VDF) for felony evading, evading peace officer (wrong way driver), an active felony warrant, possession of burglary tools (found in vehicle), and willfully harming a peace officer's animal. Addendum F, Use of Force Guidelines states, "Canines are typically used in search scenarios, for deputy protection and for apprehension of fleeing subjects wherein this degree of force is justifiable." Furthermore, Use of Force Guidelines states canines certified and approved for department use may be used to locate, apprehend, or control a felony suspect when it would be unsafe for the deputies to proceed into the area or to locate, apprehend, or control armed misdemeanor suspects. Deploying the canine to apprehend and control Manriquez was a safe and effective way to safely apprehend Manriquez, while simultaneously minimizing the risk of serious injury or death to all parties involved and citizens in the immediate area. Furthermore, SDSD P&P 6.43 entitled "Vehicle Pursuit" states a pursuit may be initiated when in the deputy's judgment an individual clearly exhibits the intention of avoiding police contact or arrest by using a vehicle to flee; and the deputy has reasonable suspicion that the individual he/she is attempting to stop or arrest has committed, is about to, or is threatening to commit a crime. The vehicle pursuit was conducted in accordance with policy. In April 2022, CLERB #21-014/Calhoun, CLERB recommended the SDSD modify P&P Section 6.43 – Vehicle Pursuit, to mandate that deputies shall not initiate or participate in a pursuit in which the only known offense at the time of the initiation or subsequent participation is a non-violent crime, to include a stolen vehicle. In May 2022, SDSD responded and chose not to implement this recommendation. There was no evidence to support an allegation of procedural violation, misconduct, or negligence on the part of the Sheriff's Department sworn personnel. The evidence showed the alleged act or conduct did occur but was lawful, justified, and proper.

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**22-073/QUINN**

1. Use of Force Resulting in Great Bodily Injury – Deputy 1 used force on Joseph Quinn resulting in injury.

Board Finding: Action justified
Rationale: On 05-29-22 Deputy 1 responded to a report of a suspicious person. The California Police Officers Legal Sourcebook (CPOLS) provided guidance in defining a legal detention. CPOLS Section 3, Detentions/Stops, stated, "For an investigative stop or detention to be valid, you must have 'reasonable suspicion' that: (1) criminal activity may be afoot and (2) the person you are about to detain is connected with that possible criminal activity… Whether you are detaining someone (1) to investigate your reasonable suspicion or (2) to issue a 'cite and release' citation, the suspect has an obligation to stop. A suspect has 'no right to resist' a lawful detention… If the suspect does not stop, he has violated Penal Code section 148 (or section 69 if force is used) by obstructing or delaying you in the performance of your duties… and you may use physical force to make him stop." In this instance, Deputy 1 had reasonable suspicion to conduct a valid detention of Joseph Quinn based on the statements of the reporting party. Deputy 1 contacted Quinn who subsequently fled on foot and a use of force ensued. As Quinn fled, he threw a cup of unknown liquid into Deputy 1's face. Quinn suffered a laceration to his head and a fractured nose when Deputy 1 placed Quinn in the prone position. No hand strikes or other intermediate weapons were used to detain Quinn. Quinn was treated at the hospital for his injuries and booked into the Vista

Detention Facility. A review of all the evidence showed the use of force was appropriate given the resistance offered by Quinn. Appropriate medical procedure was followed once it was observed Quinn sustained an injury. The evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

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**22-079/RODRIGUEZ**

1. Misconduct/Procedure – An unidentified San Diego Sheriff's Department (SDSD) deputy moved Rodriguez from his current housing assignment.

   Board Finding: Action Justified
   Rationale: In his complaint, Rodriguez alleged, "… after being assaulted by unvetted inmate… on video the sergeant working the floor moved the petitioner to Covid-19 quarantine floor… all without cause." According to SDSD documents, on 06-25-22 it was determined by medical staff that Rodriguez required to be placed in medical isolation. Based on medical staff's determination, Rodriguez was placed in medical isolation. The SDSD documentation received does not specify which specific SDSD deputy escorted Rodriguez from his previous housing to medical isolation. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

2. Misconduct/Procedure – Deputy 1 placed Rodriguez in "Enhanced Observation Housing."

   Board Finding: Action Justified
   Rationale: Rodriguez alleged, "I was immediately moved to EOH, 'Enhanced Observation Housing' for advocating for myself… and held in 36 hour observation on the word of a nurse I never spoke two words to because she had no mental health (background)." SDSD documents showed medical staff determined Rodriguez should be placed in Enhanced Observation Housing in accordance with SDSD Detention Services Bureau (DSB) policy section J.5, Suicide Prevention Practices for Incarcerated Persons & Detentions Safety Program. Based on medical staff's determination, Deputy 1 escorted Rodriguez to an Enhanced Observation Housing cell. The evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

3. Misconduct/Procedure – Unidentified sergeants and lieutenants refused to sign Rodriguez's grievances.

   Board Finding: Unfounded
   Rationale: Rodriguez alleged, "Sergeants and Lieutenants have refused to sign my grievances because they are controversial." Rodriguez presented no evidence to support his allegation. Based upon the documentation received from SDSD in this case, as well as case #22-046, in which Rodriguez filed a complaint which alleged separate actions of misconduct, it appeared this allegation lacks merit. In both cases, CLERB received copies of the grievances completed by Rodriguez and the Grievance Responses completed by SDSD staff. It appeared Rodriguez frequently used the Grievance process and received responses. SDSD records showed four sperate grievances were received from Rodriguez for the months of May and June 2022. Further, these allegations do not specifically state any staff member as responsible for denying him access. The evidence shows that the alleged act or conduct did not occur.

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**22-114/SCOTT**

1. Misconduct/Procedure – Sheriff deputies reported that Scott was a "Snitch."

   Board Finding: Summary Dismissal
   Rationale: Scott stated, "These Sheriff's came to prison and told correction officer to help torcher me so stop 'snitch' that the officer CCWF [Central California Women's Facility] prison calling me a 'snitch' as well as them." Per CLERB Rules & Regulations, Section 15: Summary Dismissal, Summary Dismissal may be appropriate in the following circumstances: Lack of cooperation by the Complainant such that CLERB is

unable to continue its investigation and a failure by the Complainant to respond to repeated inquiries when such response is necessary to the ongoing investigation.

2. Misconduct/Procedure – Sheriff deputies told State prison officers to "torture" Scott.

   Board Finding: Summary Dismissal
   Rationale: Scott stated, "These Sheriff's came to prison and told correction officer to help torcher me." See Rationale #1.

3. Criminal Conduct – State prison officers "raped" Scott.

   Board Finding: Summary Dismissal
   Rationale: Scott stated, "Now I am getting raped in prison because they told officers that I was snitch." CLERB does not have jurisdiction to investigate complaints against California Department of Correction Officers. CLERB Rules & Regulations, Section 4: Authority, Jurisdiction, Duties and Responsibilities of CLERB, Complaints: Authority. Pursuant to the Ordinance, CLERB shall have authority to receive, review, investigate, and report on complaints filed against peace officers or custodial officers employed by the County in the Sheriff's Department or the Probation Department. See Rationale #1.

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**22-144/AGUILERA**

1. Misconduct/Medical (I/O) – Unidentified jail medical staff "neglected" Aguilera's medical needs.

   Board Finding: Summary Dismissal
   Rationale: Aguilera stated, "My son has been suffering with medical issues. I am asking for someone to assist me in getting my son appropriate medical treatment." CLERB staff met with the aggrieved at George Bailey Detention Facility and confirmed that all concerns were related to medical or mental health treatment. CLERB does not have jurisdiction to investigate the actions or inactions of SDSD medical staff. CLERB Rules & Regulations, Section 4: Authority, Jurisdiction, Duties and Responsibilities of CLERB, Complaints: Authority. Pursuant to the Ordinance, CLERB shall have authority to receive, review, investigate, and report on complaints filed against peace officers or custodial officers employed by the County in the Sheriff's Department or the Probation Department. This complaint is submitted for summary dismissal per CLERB R&R Section 15: Summary Dismissal, Summary Dismissal may be appropriate in the following circumstances: CLERB does not have jurisdiction over the subject matter of the complaint.

2. Misconduct/Medical (I/O) – Unidentified jail psychiatric staff "neglected" Aguilera's mental health needs.

   Board Finding: Summary Dismissal
   Rationale: Aguilera stated, "I received another phone call last night from my son in serious pain and great anxiety that he's getting worse." CLERB does not have jurisdiction to investigate the actions or inactions of SDSD psychiatric staff. See Rationale #1.

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***End of Report***

**NOTICE**

In accordance with Penal Code Section 832.7, this notification shall not be conclusive or binding or admissible as evidence in any separate or subsequent action or proceeding brought before an arbitrator, court or judge of California or the United States.