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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 October 17, 2023, meeting held in person. 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 (9)

ALLEGATIONS, BOARD FINDINGS & RATIONALES
Changes from Recommended Findings or Revised Content of Rationale or Verbiage Highlighted in Red

22-014/CORRALES (DEATH)

1. Death Investigation/Officer-Involved Shooting – San Diego Sheriff's Department (SDSD) Detective Anthony Garcia used lethal force against Mizael Corrales.

   Board Finding: Action Justified
   Rationale: CLERB Rules and Regulations, Section 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents, states, "CLERB shall have authority to review, investigate, and report on the following categories of incidents, regardless of whether a Complaint has been filed… The death of any individual arising out of or in connection with actions of peace officers or custodial officers employed by the County in the Sheriff's Department or the Probation Department, arising out of the performance of official duties." According to SDSD documents, on 02-19-22, two detectives began their shift, partnered together in an unmarked SDSD vehicle. Both detectives were dressed in plain clothing. The unmarked vehicle was equipped with License Plate Reading (LPR) cameras. Deputy 1 and Detective Garcia began their shift partnered together in a standard SDSD marked patrol vehicle. Deputy 1 and Detective Garcia were dressed in standard deputy uniform. All four Detectives were assigned to the SDSD Border Crime Suppression Team (BCST). According to SDSD reports of the incident, the plain clothes detectives drove their unmarked vehicle through the shopping center parking lot at 2494 Roll Drive, San Diego. While driving through the parking lot, the unmarked vehicles LPR provided an alert for a reported stolen vehicle, a white SUV. The plain clothes detectives broadcasted the information by radio and requested the assistance of Deputy 1 and Detective

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Garcia, who were in their marked SDSD vehicle. Once on scene, Deputy 1 and Detective Garcia parked there marked SDSD vehicle behind and to the side of the SUV, in a way that did not block it, and the four detectives approached the vehicle. Inside the vehicle was Mizael Corrales and two additional passengers in the back seats. According to SDSD reports, Deputy 1 and Detective Garcia contacted Corrales in the driver's seat of the vehicle, and a struggle ensued as they attempted to remove Corrales. In addition to reports of this incident, BWC from Detective Garcia, and security camera footage from nearby business, were used to evaluate this incident. The evidence showed Corrales continued to resist Deputy 1 and Detective Garcia, who were positioned inside of the open door of the SUV, when Corrales suddenly and rapidly accelerated backwards. The open door of the vehicle struck Deputy 1 and Detective Garcia, throwing them violently onto the ground. Corrales continued reversing the Mercedes and collided with two parked vehicles. The new positioning of the SUV placed Detective Garcia directly in its path. Just behind Detective Garcia was Deputy 1, a plain clothed detective, and one of the passengers who was initially in the vehicle. Fearing Corrales would accelerate forward using the vehicle to kill him and his partners, Detective Garcia discharged his firearm at Corrales. The vehicle stopped when it struck the rear of the parked unmarked SDSD vehicle. The following SDSD P&P and CA law should be considered when evaluating this use of force incident. CA Penal Code (PC) section 835a(c)(1)(A), stated, "… a peace officer is justified in using deadly force upon another person only when the officer reasonably believes, based on the totality of the circumstances, that such force is necessary for either of the following reasons: To defend against an imminent threat of death or serious bodily injury to the officer or to another person… To apprehend a fleeing person for any felony that threatened or resulted in death or serious bodily injury, if the officer reasonably believes that the person will cause death or serious bodily injury to another unless immediately apprehended. Where feasible, a peace officer shall, prior to the use of force, make reasonable efforts to identify themselves as a peace officer and to warn that deadly force may be used, unless the officer has objectively reasonable grounds to believe the person is aware of those facts." Regarding how "totality of the circumstances" is defined, CA PC section 835a(e)(3) stated, "'Totality of the circumstances' means all facts known to the peace officer at the time, including the conduct of the officer and the subject leading up to the use of deadly force." Importantly, CA PC section 835a(4), stated, "That the decision by a peace officer to use force shall be evaluated from the perspective of a reasonable officer in the same situation, based on the totality of the circumstances known to or perceived by the officer at the time, rather than with the benefit of hindsight, and that the totality of the circumstances shall account for occasions when officers may be forced to make quick judgments about using force." SDSD P&P section 2.49, Use of Force, stated, "Employees shall not use more force in any situation than is reasonably necessary under the circumstances. Employees shall use force in accordance with law and established Departmental procedures, and report all use of force in writing." Regarding the use of "lethal force," SDSD P&P Addendum Section F stated, "Deputies may only use lethal force when they reasonably believe, based on the totality of the circumstances, that lethal force is necessary to defend against an imminent threat of death or serious injury to the deputy or to another person; or to apprehend a fleeing person for any felony that threatened or resulted in death or serious bodily injury, if the deputy reasonably believes that the person will cause death or serious bodily injury to another unless immediately apprehended. In situations where lethal force is necessary to defend against an imminent threat of death or serious injury to the deputy or to another person, deputies may use any method of force which is necessary and objectively reasonable to neutralize the threat in defense of human life." On 02-20-22, an autopsy of Corrales was conducted at the SDMEO. The cause of death was multiple (six) gunshot wounds, and the manner of death was homicide. Toxicology testing of blood specimens taken were presumptive positive for amphetamines and cannabinoids. On 11-08-22, San Diego County District Attorney Summer Stephan released a letter detailing the District Attorney's Office's finding regarding this incident. As stated in the letter, "Reviewing the evidence and considering the totality circumstances, Garcia reasonably believed that Corrales, in his attempt to flee, posed an imminent threat and intended to cause serious bodily harm or death to Garcia, other deputies and bystanders. Less lethal alternatives were not feasible or safe against the immediate and lethal threat posed by Corrales. Therefore, Garcia bears no state criminal liability for his actions." CLERB's own evaluation of this case showed, when evaluating the totality of circumstances presented to Detective Garcia, he reasonably believed he and his partners were at risk of great bodily injury or death, and that the force used was within policy and legally justified. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

2. Misconduct/Procedure – Deputy 1 failed to activate his Body Worn Camera prior to a use of force incident.

Board Finding: Sustained
Rationale: When evaluating evidence associated with this case, it was noted that Deputy 1's Body Worn Camera (BWC) was not activated until after the shooting had occurred. SDSD P&P section 6.131, Body Worn Cameras, stated, "When responding to a call for service, a deputy/CSO shall activate their BWC in record mode prior to arriving on scene or upon arrival and prior to exiting their patrol vehicle. In situations where activation was not accomplished prior to arriving on scene, those reasons shall be articulated in writing via case related report, or if no report, in CAD." It should be noted, as is standard practice in deputy involved shootings, the victim deputies provided verbal statements and did not complete written reports. As such, a written rationale as to why Deputy 1 did not activate his BWC was unavailable. A Sheriff Employee Response Form (SERF) was sent to Deputy 1, requesting a rationale for why his BWC was not activated prior to the approach of Corrales. A response was received from Deputy 1, and the confidential statements made in the SERF were considered when determining a finding with this allegation. The available evidence showed that there was a clear technical violation of BWC policy. Simply, Deputy 1 had a BWC, and did not activate it prior to his contact with Corrales. However, when further evaluating this allegation, while there was a technical violation of the BWC policy, Deputy 1's responses in the SERF provided a reasonable rationale as to why the BWC was not activated. Additionally, Deputy 1's actions did not appear to be indicative of, or contributing to, any larger pattern or practice of misconduct. The evidence supports the allegation and the act or conduct was not justified.

22-043/LACY (DEATH)

1. Death Investigation/In-custody Medical – Jerrell Dwayne Lacy, while an inmate at San Diego Central Jail (SDCJ) was found unresponsive in his cell on 04-11-22.

   Board Finding: Not Sustained
   Rationale: The evidence supported that Lacy was properly classified upon his entry into the SDSD jail system after his arrest. Lacy's medical records indicated he refused COVID-19 testing on 08-11-21 but did not indicate a refusal of the COVID-19 vaccine. Medical notes indicated Lacy expressed COVID concerns when seen by medical staff. In a presentation at a CLERB meeting on 01-11-22 by Sergeant Dennis, he stated all Incarcerated Persons (IPs) are asked if they would like a COVID vaccine during the booking process. Sergeant Dennis also stated while in intake and during any subsequent medical encounters, unvaccinated IPs are counseled by medical staff on the importance of receiving the COVID-19 vaccine. Sergeant Dennis stated if an IP refuses a vaccine, it is reported and documented by medical staff. In a SDSD News Release on 08-13-21, five days following Lacy's intake, "to date, our medical staff has offered the vaccine to 13,627 individuals. 9,239 refused and 4,388 have accepted a combination of first and second doses." SDSD records showed on 04-02-22 Lacy was involved in a Use of Force incident which involved fist strikes to Lacy's face and abdomen, knee strikes to Lacy's right leg, and left bicep/tricep area, and Conducted Energy Device (CED) deployment. SDSD records showed on 04-03-22 after Lacy returned from Tri-City Hospital from the Use of Force incident, he notified medical staff that he planned on hurting himself and was placed in EOH. According to SDSD DSB P&P J.4 (in effect at the time) titled, "Enhanced Observation Housing (EOH): Definition and Use", states "Inmates in EOH shall be closely monitored and directly observed by sworn staff at random intervals not to exceed 15 minutes between checks. Such observations shall be documented in the Jail Information System (JIMS)." The policy in effect at the time also stated, "a JIMS incident report utilizing "EOU" (enhanced observation update) as the primary incident type code shall be documented by sworn staff at least every 24 hours or after each Qualified Mental Health Provider (QMHP) assessment to document the continued need or clearance from ISP housing." Lacy's first mental health assessment following this EOH placement was conducted my SDSD Jail Mental Health staff at 09:43AM on 04-03-22. According to Jail Medical records, Lacy was cleared from EOH on 04-03-22 at 7:45PM. According to SDSD Medical Records on 04-11-22 at approximately 9:37AM Lacy denied any signs and symptoms of COVID during a group health check. Following the health check, hard count occurred at 9:58AM. SDSD DSB P&P section I.43 Inmate Count Procedure states, "All inmates at each detention facility shall be accounted for. Sworn staff will physically conduct counts of inmates. All counts require sworn staff to verify each inmate's well-being through "verbal or physical acknowledgement" from the inmate. There

was no noted safety or health concerns noted during the hard count. According to the Area Activities Summary Report, safety checks were started in Lacy's housing area at 10:06AM, 10:41AM, and 11:01AM. CLERB requested jail video evidence during this time period but due to the length of time since the incident, the department no longer had the video evidence. Due to the lack of video evidence, CLERB was unable to visually verify the safety checks prior to Lacy's first discovery. SDSD produced Jail Video Surveillance from 11:06AM to 12:36PM. SDSD records showed at approximately 11:07AM, Lacy was escorted to medical due to shortness of breath. SDSD records showed deputies were notified by IPs housed in D module of a "person down." In an interview with Homicide detectives, Deputy 1 stated, "the entire module in David was yelling man down". Deputies entered and escorted Lacy to third floor clinics. Jail Video Surveillance showed when Lacy exited his cell, he fell to the ground. Deputies assisted and helped Lacy stand up and he was able to walk to the clinics area. According to interviews with the Detentions Investigations Unit (DIU), several IPs stated they hit the callbox for an extended amount of time before deputies responded. IP, Bryan Meyers said they attempted to get medical attention for 30 minutes before deputies arrived. IP, David Johnson stated the callbox didn't work and a group of IPs yelled to get the deputies attention. In an interview with DIU, IP, Kevin Freeman stated it took approximately 45 minutes to get deputies to respond. According to SDSD P&P Section I.2, Intercom Systems are accessible to inmates to provide a means of communication between inmates and sworn staff. SDSD P&P I.2, states, "In the event an intercom is inoperable, sworn staff shall report the issue to their respective administrative deputy or operations deputy. Upon notification of the issue, the administrative deputy or operations deputy will contact the security technician. The security technician will assess the issue and contact the contracted provider to remedy the problem. If the security technician is not available, the administrative deputy or operations deputy will relay the information to the Sheriff's Project Manager." SDSD records produced no records of intercom issue or of a muted intercom in cell 6. SDSD Medical Records showed Lacy was seen by medical on 04-11-22 at 11:48AM for shortness of breath and chest pain. During Lacy's medical visit, his vitals were normal, but his EKG (electrocardiogram) showed significant changes from his prior EKG. Lacy was cleared by medical staff to return to housing and was escorted back to his cell. According to an interview with Jail Medical Staff, a nurse was in the process of alerting medical staff of a need for an emergency room transport due to the EKG disparities when Lacy went man down. Jail Video Surveillance showed Lacy was brought back to his housing via wheelchair at 11:49AM. Lacy appeared to stand up and walk into his cell on his own. Jail Video Surveillance showed at 12:00PM Deputy 1 arrived at Lacy's cell door. Deputy 1 shined his flashlight into the cell. Deputy 1 opened the cell door approximately 40 seconds later. Deputy 1 appeared to be conversing at the cell door then entered the cell. Jail Video Surveillance showed Deputy 1 get down on the floor at 12:01PM and started lifesaving measures. According to SDSD records, Deputy 1 administered two doses of Narcan and started chest compressions. Jail Medical staff arrived at 12:03PM and took over chest compressions. According to SDSD records, an AED (automated external defibrillator) was applied, and no shock was advised. SDSD records stated CPR was continued with breaks for AED rhythm checks. Furthermore, Jail Medical records indicated jail medical staff attempted to insert IV multiple times but were unsuccessful. Paramedics arrived at 12:13PM and took over lifesaving measures. Lacy was transported to UCSD Medical Center at 1241PM. Upon arrival at UCSD, Lacy was intubated, and CPR was continued by staff. Despite aggressive lifesaving measures, Lacy was pronounced dead at 1:08PM on 04-11-22. The cause of death was pulmonary thromboemboli, due to deep venous thromboses of lower extremities, with COVID-19 Infection as contributing, and the manner of death was natural. Toxicology testing of blood specimens taken while Lacy was at the hospital were negative for alcohol or common drugs of abuse. CLERB was unable to verify the length of time from when IPs notified deputies of a medical emergency to the time deputies arrived (for Lacy's first discovery). There was insufficient evidence to either prove or disprove the allegation.

2. Misconduct/Procedure - SDSD did not retain jail incident videos.

Board Finding: Not Sustained
Rationale: Through the course of investigation, CLERB discovered Jail Video Surveillance hours prior to the death were not retained. SDSD produced Jail Video Surveillance from 11:06AM to 12:36PM. According to an email from Rosy Flores, Support and Compliance Sergeant at San Diego Central Jail (SDCJ), the Jail Video Surveillance system is only able to review six months back. The San Diego County Retention Policy Schedule Report for Owning Department: SH states Facility Incident Videos should be retained for a retention time frame of two years. While the Retention Policy Schedule does not define "facility incident

videos", the SDSD P&P states in custody deaths "are deemed critical incidents and shall be reviewed by the Critical Incident Review Board (CIRB)". Furthermore, the policy does not define the timeframe prior and after an incident for retention. To improve ambiguity in retention schedules and ability to review critical incidents in entirety, it is recommended the San Diego Sheriff's Department (SDSD) define facility incident video retention to include all critical incidents as defined by SDSD P&P 4.23 Department Committees and Review Boards-Critical Review Board. CLERB recommends facility incident videos are retained for twelve hours prior to and after incident occurrence. Due to the ambiguity in retention schedule policy, there was insufficient evidence to either prove or disprove the allegation.

3. Misconduct/Procedure - Unidentified deputies misclassified Lacy.

   Board Finding: Unfounded
   Rationale: Attorney Lauren Williams, on behalf of Jerrell Lacy's family stated," Deputies should have housed Lacy in a housing unit where he would have been monitored more closely due to his mental health and health issues." Lacy was classified as "5 HIGH." As per SDSD P&P R.3 entitled, "Inmate Classification Code-Descriptor Definitions," a classification of 5-Maximum indicates "This inmate must have a combination of two of the following: current assaultive charges, prior assaultive history, are deemed an institutional behavior problem or an escape risk. Inmates classified as assaultive, or escape risks (Greenbander) will be classified as a minimum level 5." SDSD records showed Lacy was classified as a Greenbander due to an assault to staff incident. The evidence showed the act or conduct did not occur and Lacy was classified in accordance with policy.

4. Misconduct/Medical – Unidentified Medical Personnel did not place Lacy in a proper housing unit.

   Board Finding: Summary Dismissal
   Rationale: Attorney Lauren Williams, on behalf of Jerrell Lacy's family stated," Deputies should have housed Lacy in a housing unit where he would have been monitored more closely due to his mental health and health issues." SDSD DSB P&P Section M.9 entitled, "Intake Medical Screening," in effect at the time of the incident was as follows, "All arrestees presented by arresting agencies shall be medically screened prior to acceptance for booking at a Sheriff's detention facility. Arrestees who require urgent and immediate medical care shall not be accepted for booking." Attorney Williams stated," Deputies should have housed Lacy in a housing unit where he would have been monitored more closely due to his mental health and health issues." SDSD DSB P&P J.4 titled" Enhanced Observation Housing (EOH): Definition and Use" establishes procedures for IPs who have been determined by the facility gatekeeper to warrant placement in the Inmate Safety Program (ISP) because they present an increased risk for suicide and who do not require placement in a safety cell. According to the policy, the facility gatekeeper determines whether a placement into ISP is warranted. DSB P&P J.5 states the facility gatekeeper is a Qualified Mental Health Provider (QMHP) or assigned designee in their absence. A QMHP refers to a Psychologist, Psychiatrist, Licensed Mental Health Clinician (MHC), Psychiatric Nurse Practitioner (PNP), or contracted Psychiatric Registered Nurse (PRN). According to SDSD Medical Records, it was indicated Lacy had a History of ISP placement notated in his mental health history receiving screening. It was also indicated Lacy was under the influence of "ETOH" or ethyl alcohol per the Arresting Officer. Lacy was cleared by medical staff as "fit to continue booking." SDSD records showed on 04-03-22 after Lacy returned from Tri-City Hospital from the Use of Force incident, he notified medical staff that he planned on hurting himself and was placed in EOH. According to SDSD DSB P&P J.4 (in effect at the time) titled, "Enhanced Observation Housing (EOH): Definition and Use," states "Inmates in EOH shall be closely monitored and directly observed by sworn staff at random intervals not to exceed 15 minutes between checks. Such observations shall be documented in the Jail Information System (JIMS)." The policy in effect at the time also stated, "a JIMS incident report utilizing "EOU" (enhanced observation update) as the primary incident type code shall be documented by sworn staff at least every 24 hours or after each Qualified Mental Health Provider (QMHP) assessment to document the continued need or clearance from ISP housing." Lacy's first mental health assessment following EOH placement was conducted my SDSD Jail Mental Health Staff at 09:43AM on 04-03-22. According to Jail Medical records, Lacy was cleared from EOH on 04-03-22 at 7:45PM. Medical decisions such as EOH clearance are made by medical personnel and as such CLERB lacks jurisdiction to investigate further. Medical decisions/actions, to include "fit for booking" status, ISP and EOH placement, are made by medical staff who are non-sworn

personnel and do not fall under CLERB's jurisdiction. Pursuant to CLERB Rules and Regulations, Section 4.1 Complaints: Authority, stipulates that CLERB only has authority to investigate complaints filed against peace/custodial officers employed by the San Diego Sheriff's Department. The Review Board lacks jurisdiction.

5. Misconduct/Procedure – Deputy 3 failed to respond to intercom.

   Board Finding: Not Sustained
   Rationale: According to interviews with the Detentions Investigations Unit (DIU), several IPs stated they hit the callbox for an extended period before deputies responded. IP, Bryan Meyers said they attempted to get medical attention for 30 minutes before deputies arrived. IP, David Johnson stated the callbox didn't work and a group of IPs yelled to get the deputies attention. In an interview with DIU, IP, Kevin Freeman stated it took approximately 45 minutes to get deputies to respond. According to SDSD P&P Section I.2, Intercom Systems are accessible to inmates to provide a means of communication between inmates and sworn staff. SDSD P&P I.2, states, "In the event an intercom is inoperable, sworn staff shall report the issue to their respective administrative deputy or operations deputy. Upon notification of the issue, the administrative deputy or operations deputy will contact the security technician. The security technician will assess the issue and contact the contracted provider to remedy the problem. If the security technician is not available, the administrative deputy or operations deputy will relay the information to the Sheriff's Project Manager." SDSD records produced no records of intercom issue or of a muted intercom in cell 6. SDSD produced Jail Video Surveillance from 11:06AM to 12:36PM. The suggested delay in response occurred prior to 11:06AM and as such CLERB was unable to investigate further. Deputy 3 provided confidential information, via questionnaire, during CLERB's investigation that was considered in arriving at the recommended finding. Deputy statements provided during administrative investigations are deemed confidential by law and cannot be publicly disclosed. There was insufficient evidence to either prove or disprove the allegation.

6. Misconduct/Procedure – Deputies 1 and 2 delayed taking Lacy to medical.

   Board Finding: Not Sustained
   Rationale: Attorney Williams stated, "When Lacy first requested medical attention on the morning of April 11, 2022, staff took an unreasonable amount of time to respond and take him to see medical staff." SDSD DSB P&P M.5, provides guidelines for response to medical emergencies. The policy states, "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." SDSD DSB P&P M.15 titled "Sick Call", states "Inmates in need of urgent medical attention shall be immediately referred to health staff." There was no way to determine if there was a delay in response time from when IPs attempted to alert staff and when staff arrived at approximately 11:07AM. Deputies 1 and 2 provided confidential information, via questionnaire, during CLERB's investigation that were considered in arriving at the recommended finding. Deputy statements provided during administrative investigations are deemed confidential by law and cannot be publicly disclosed. *See Rationale 5*

7. Misconduct/Procedure- Deputies 1 and 2 did not "immediately" alert emergency services.

   Board Finding: Not Sustained
   Rationale: Attorney Lauren Williams, on behalf of Jerrell Lacy's family stated, "Deputies and medical staff failed to immediately alert emergency services despite that Lacy was found on the floor of his cell with chest pain and difficulty breathing on the morning of April 11, 2022." Williams also stated, "Staff failed to properly or timely initiate a 911 response as evidenced by the CIRB recommendation for the publication of a training bulletin regarding such protocols." SDSD DSB P&P M.6 titled, "Life Threatening Emergencies: Code Blue," states "Any life-threatening medical emergency shall trigger a 911 request for a paramedic emergency response team." The policy in effect at the time defined a code blue as, "A code blue is generally used to indicate the need for resuscitation or immediate lifesaving medical attention. This includes, but is not limited to cardiac arrest, respiratory arrest, and trauma emergencies." Jail Video Surveillance showed when Lacy exited his cell, he fell to the ground. Deputies assisted and helped him stand up and he was able to walk to

the clinics area. Lacy was evaluated by SDSD Jail Medical Staff. SDSD records indicated Lacy's vitals were normal and he was cleared to return to housing. Jail Video surveillance showed Lacy was brought back to his housing via wheelchair at 11:49AM. Lacy appeared to stand up and walk into his cell on his own. Jail Video Surveillance showed at 12:00PM Deputy 1 arrived at Lacy's cell door. Deputy 1 shined his flashlight into the cell. Deputy 1 opened the cell door approximately 40 seconds later. Deputy 1 appeared to be conversing at the cell door then entered the cell. Jail Video Surveillance showed Deputy 1 get down on the floor at 12:01PM. According to an interview with Homicide detectives, Deputy 1 immediately initiated lifesaving measures. According to SDSD records, 911 was already activated by Jail Medical staff at approximately the same time Lacy went "man-down." Deputies 1 and 2 provided confidential information, via questionnaire, during CLERB's investigation that were considered in arriving at the recommended finding. Deputy statements provided during administrative investigations are deemed confidential by law and cannot be publicly disclosed. Although Jail medical records showed Lacy was cleared to return to housing and SDSD records indicated Lacy was able to walk and converse on his own, he suffered a life-threatening emergency that ultimately led to his death. Prior to his death Lacy complained to deputies and medical personnel of shortness of breath and difficulty breathing. There was insufficient evidence to prove or disprove the allegation.

8. Misconduct/Medical - Unidentified Medical staff did not "immediately" alert emergency services.

   Board Finding: Summary Dismissal
   Rationale: Attorney Lauren Williams, on behalf of Jerrell Lacy's family stated," Deputies and medical staff failed to immediately alert emergency services despite that Lacy was found on the floor of his cell with chest pain and difficulty breathing on the morning of April 11, 2022." SDSD Medical Records showed Lacy was seen by medical on 04-11-22 at 11:48AM for shortness of breath and chest pain. Jail video surveillance showed Lacy was brought back to his housing via wheelchair at 11:49AM. During Lacy's medical visit, his vitals were normal, but his EKG showed significant changes from his prior EKG. According to an interview with Nurse [REDACTED], he/she was in the process of alerting medical staff of a need for an emergency room transport due to the EKG changes when she heard the man-down. Pursuant to CLERB Rules and Regulations, Section 4.1 Complaints: Authority, stipulates that CLERB only has authority to investigate complaints filed against peace/custodial officers employed by the San Diego Sheriff's Department. The Review Board lacks jurisdiction.

9. Misconduct/Medical – SDSD Medical staff did not provide medical care.

   Board Finding: Summary Dismissal
   Rationale: Attorney Lauren Williams, on behalf of Jerrell Lacy's family stated, "medical staff failed to timely read Lacy's EKG" and "Medical staff (including NP [REDACTED] and the "clinic nurse") and deputies failed to immediately alert emergency services despite significant abnormal changes in EKG results." Williams also stated, "In the days leading up to Lacy's death, jail staff failed to provide Lacy with adequate medical attention despite obvious signs of health issues such as shortness of breath, chest pain, headaches, and lethargy." SDSD Medical Records showed Lacy was seen by medical on 04-11-22 at 11:48AM for shortness of breath and chest pain. During Lacy's medical visit, his vitals were normal, but his EKG showed significant changes from his prior EKG. According to an interview with Nurse [REDACTED], he/she was in the process of alerting medical staff of a need for an emergency room transport due to the EKG changes when she heard the man-down. Pursuant to CLERB Rules and Regulations, Section 4.1 Complaints: Authority, stipulates that CLERB only has authority to investigate complaints filed against peace/custodial officers employed by the San Diego Sheriff's Department. The Review Board lacks jurisdiction.

POLICY RECOMMENDATION:

1. It is recommended the San Diego Sheriff's Department (SDSD) define facility incident video retention to include all critical incidents as defined by SDSD P&P 4.23 Department Committees and Review Boards-Critical Review Board. CLERB also recommends facility incident videos are retained for twelve hours prior to and after incident occurrence.

22-093/BOUSMAN (DEATH)

1. Death Investigation/Drug Related - James Bousman, while an inmate at Vista Detention Facility, was found unresponsive in his cell on 07-26-22.

   Board Finding: Not Sustained
   Rationale: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. Bousman was a 23-year-old White/Hispanic male who reportedly resided in the North County area. (CLERB was unable to verify Bousman's race. SDSD records identified him as Hispanic while ME records listed him as white.) According to SDSD documentation, on 03-09-22, Bousman was arrested by the Oceanside Police Department on a felony probation violation, assault on a peace officer and ultimately booked into the Vista Detention Facility (VDF). Bousman was housed appropriately according to his classification. SDSD documentation showed Bousman had a history of illicit drug use and other medical conditions. Evidence showed that on 07-26-22, deputies conducted safety and security checks in accordance with policy. The last floor count was conducted by an unidentified deputy where he acknowledged that Bousman provided a verbal and physical response. Approximately forty minutes later, an unidentified deputy conducted a safety and security check when he saw that Bousman was nonresponsive. The control deputy opened the cell door, deputies called for jail medical staff, activated 911 and began chest compressions and administered Narcan. Jail medical staff arrived and continued lifesaving efforts until paramedics arrived. Bousman was then transported to Tri-City Medical Center where he was pronounced deceased on 07-27-23 at approximately 11:15am. On 07-28-22, San Diego Medical Examiner's Office (SDMEO) conducted an autopsy of James Bousman at the SDMEO. The cause of death was complications of resuscitated cardiopulmonary arrest due to acute fentanyl intoxication and the manner of death was accident. According to the Toxicology report, fentanyl (and its metabolite, norfentanyl) was detected. Medications, alcohol or other illicit drugs were not detected. Although there was no policy violation(s) found with deputies' response to Bousman's medical emergency, evidence showed that fentanyl was directly correlated to his death, and therefore Bousman's death was preventable. There was insufficient evidence to either prove or disprove the allegation.

   On August 23, 2022, CLERB recommended that SDSD physically search or body scan all persons entering a SDSD-operated detention facility, to include all SDSD employees, County employees, contractors, and those persons conducting county-related business. "All persons" also includes social and professional visitors and incarcerated persons (I/Ps) upon booking and transferring between facilities or re-entering a facility after having departed it for court, medical treatment, etc. On December 28, 2022, SDSD advised CLERB it would not implement the searching or scanning recommendations. On January 18, 2023, as there was a new SDSD Sheriff, CLERB re-submitted the policy recommendations and asked for reconsideration of the former SDSD Sheriff's original declination. As of October 17, 2023, CLERB has yet to receive a response.

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

   Board Finding: Sustained
   Rationale: Although SDSD has implemented numerous measures to deter drugs from entering its detention facilities, Incarcerated Person Bousman was under the care of the SDSD when he acquired and subsequently consumed fentanyl, which resulted in his death. According to the SDSD News Release, "Stopping Drug Smuggling in County Jails," dated 04-19-21, the SDSD is active in their attempts to intercept drugs into the facilities. Some efforts being made are the use of body scanners at all intake facilities and GBDF, inmate screening and flagging of potential smugglers. Also, the mail processing center has special equipment for drug detection, drug detection K-9's, and a "no questions asked" drug drop box. SDSD also provides drug education and awareness in the facilities. Additionally, in accordance with DSB P&P I.41, Inmate Cell Searches and DSB P&P L.2 Sanitation and Hygiene Inspections, cell searches and inspections were performed in an effort to provide a safe and secure environment free of contraband. The investigation failed to determine how the contraband entered the detention facility. Despite all interdiction efforts, fentanyl

contributed to Bousman's death, and therefore this death was preventable. The evidence indicated that the SDSD failed to prevent illicit drugs from entering the detention facility and that act or conduct was not justified.

22-099/CUEVAS

1. Use of Force Resulting in Great Bodily Injury – Deputies Banaga and Nevitt used force towards Liborio Cuevas.

   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 07-10-22, deputies responded to a call that involved Liborio Cuevas, where he was a suspect of a felony assault and reportedly had a firearm. Deputies arrived at his residence, where they witnessed him drive by and refuse to stop after deputies attempted to flag him down. A vehicle pursuit ensued for approximately one mile when Cuevas finally stopped and parked in a driveway. Deputy Nevitt reported he provided Cuevas with several commands and warnings to put his hands up or he would release a canine, but Cuevas did not comply. Deputy Banaga also reported he arrived on scene and ordered Cuevas to put his hands up, but he did not comply. Deputy Nevitt released his canine, but the dog bite reportedly had little effect on Cuevas which was associated with someone who has high pain tolerance due to drugs/alcohol use. Deputy Nevitt attempted to handcuff Cuevas who reportedly "tensed his muscles" and actively resisted deputies. Deputy Banaga reported, "In fear he was going to reach for a gun, I delivered three closed fisted strikes to his face with the soft palm of my hand" resulting in compliance. Cuevas was treated on scene by paramedics, transported to a hospital and booked into San Diego Central Jail with felony charges. Addendum F, Use of Force Guidelines states deputies may only use a level of force they reasonable believe is proportional to the seriousness of the suspected offense or the reasonably perceived level of actual or threatened resistance. Cuevas' initial contact with deputies rose to the level of active resistance, as he continued to drive his vehicle towards deputies and even refused to stop during a vehicle pursuit. Deputies attempted to gain his compliance when they gave verbal commands and displayed their firearm, but he did not comply and became combative when deputies attempted to subdue him. Addendum F, reports that the use of canines to arrest a subject is considered intermediate force, which is less severe than lethal force. Based on all known evidence, the use of force was reasonable and there were no policy violations. The evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

2. Misconduct/Procedure – Deputies 1 and 2 delayed activating their Body Worn Camera (BWC).

   Board Finding: Action Justified
   Rationale: SDSD P&P Section 6.131 Body Worn Camera states, "Deputies shall begin recording prior to arriving to an incident if the call has the potential to involve immediate enforcement action upon arrival." Policy also states, "The record mode of the camera should be activated prior to actual contact with a citizen (victim/witness/suspect), or as soon as safely possible, and continue recording until the contact is completed." SDSD evidence showed that Deputy 1 participated in a vehicle pursuit, and turned on his BWC shortly after he arrived on scene. His BWC captured the use of force incident but did not capture the vehicle pursuit. Deputy 2's BWC was also not activated until after the vehicle pursuit. Deputies 1 and 2 provided confidential statements, which were considered in arriving at the recommended finding. There was no complaint of wrongdoing and the evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

22-140/NOHRA

1. Misconduct/Procedure – Unidentified deputies did not respond to Nohra's call(s) for assistance.

   Board Finding: Unfounded

Rationale: The complainant, Meri Nohra, said she called the Pine Valley Sheriff nineteen times, but they "flat refused to come inside" due the condition of her home. SDSD documentation showed that on 08-01-22, Nohra contacted 911 emergency and requested paramedics for some health issues. Body Worn Camera (BWC) and San Diego Sheriff's Department (SDSD) documentation showed that Deputy 1 responded to Nohra's home, performed a welfare check, and found her to be "gravely disabled," then placed Nohra on a "5150" (mental illness) hold. Assembly Bill [AB] 1572 Mental Health Services states, "Existing law, for the purposes of involuntary commitment and conservatorship, defines 'gravely disabled,' among other things, as a condition in which a person, as a result of a mental health disorder, is unable to provide for the basic personal needs of food, clothing, or shelter." Paramedics responded to assess Nohra and then transported her to a hospital where she was subsequently released on an unknown date. On the evening of 08-05-22, Nohra again called 911 several times and reported an "unknown subject" was on her property. SDSD documentation noted her as a "chronic caller" and a "possible 5150." Deputy 1 responded to Nohra's home on 08-06-22 to perform another welfare check and Nohra was once again placed on a 5150 hold as she was found to be gravely disabled. SDSD documentation confirmed there were several referrals generated to Adult Protective Services (APS) and other 5150 holds for Nohra on 12-21-21, 04-01-22, as well as 08-01-22 and 08-06-22. The evidence showed that Deputy 1 and SDSD responded to the complainant's calls for service and the alleged act or conduct did not occur.

2. Illegal Search & Seizure – Unidentified deputies broke a lock on Nohra's property.

   Board Finding: Unfounded
   Rationale: Nohra alleged that Sheriff deputies broke the lock on her fence and stated, "no more locks on your fence" then arrested her. Documentation showed Nohra suffers from a mental health disorder that may cause hallucinations, delusions, confused thoughts/disorganized speech. Deputy 1 responded to Nohra's request for service and turned on his BWC prior to arrival at the residence. BWC evidence refuted this allegation and the complainant was found not to be credible in her recall of a broken lock(s). There was no evidence that showed the alleged act or conduct to have occurred.

3. Illegal Search & Seizure – Deputy 1 entered Nohra's residence.

   Board Finding: Action Justified
   Rationale: Nohra alleged that Sheriff deputies entered her home and arrested her. BWC confirmed that Deputy 1 entered Nohra's home and retrieved her personal items on two occasions. According to California Peace Officer Legal Sourcebook (CPOLS) an officer may enter premises without a warrant, probable cause, or exigent circumstances if they have obtained valid consent. On 08-01-22, Nohra provided consent to Deputy 1 to enter her home with the purpose to retrieve her purse. On 08-06-22, Nohra asked Deputy 1 to retrieve personal items from inside her house before she was transported to a hospital. The evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

4. False Arrest – Deputy 1 placed Nohra on a "5150" hold.

   Board Finding: Action Justified
   Rationale: Nohra alleged that Sheriff deputies came to her home, arrested her and forced her to go to the hospital on a 5150 hold. According to the Welfare Institutions Code a 5150 could be defined as follows: "When a person, as a result of a mental health disorder, is gravely disabled, a peace officer may, upon probable cause, take, or cause to be taken, the person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment in a facility designated by the county for evaluation and treatment and approved by the State Department of Health Care Services." According to SDSD Patrol policy, "When deputies are faced with a situation where discretion can be exercised, they must evaluate the circumstances, consider the available resources, and rely on their training, Sheriff's Department policies and procedures, statutory law, information-led policing, and supervision in making the appropriate decision." Deputy 1 completed an "Application for assessment, evaluation, and crisis intervention or placement for evaluation and treatment" (DHCS 1801 form) and specified there was "probable cause" to believe Nohra was a "gravely disabled adult" based upon Nohra's appearance, statements and living conditions. Deputy 1 exercised his discretion when he authorized a hold

on Nohra. The evidence showed that the alleged act or conduct did occur but was lawful, justified and proper. deplorable

5. Criminal Conduct – Unidentified deputies "stole" property from Nohra's residence.

   Board Finding: Unfounded
   Rationale: Nohra reported that unidentified deputies moved a "big green truck" onto her property, "hauled her junk" away and stole some of her personal items. She made several nonsensical statements and stated the deputy "demanded" her parent's personal belongings. Nohra suffers from a mental health disorder that may cause hallucinations, delusions, confused thoughts/disorganized speech. Nohra provided no evidence to support her statements and there was no documentation that showed the SDSD was involved in "hauling away her junk" nor were there any reports of stolen property associated with this incident. BWC evidence confirmed a "church group" had offered Nohra assistance but she refused their help. There was no evidence to support that the alleged act or conduct occurred.

23-005/GARCIA

1. Misconduct/Procedure – Unidentified deputies ignored Andrew Garcia's intercom call(s).

   Board Finding: Not Sustained
   Rationale: The complainant, Andrew Garcia stated deputies ignored his intercom calls and said it occurred several times while he was housed at San Diego Central Jail (SDCJ). Garcia reported that when he pressed the intercom button inside his cell, there was "usually no response." According to SDSD Detentions Services Bureau (DSB) Policy & Procedure (P&P) Intercom Systems are placed to provide a means of communication between sworn staff and incarcerated persons. Intercom systems should be primarily used as a means of relaying and or summoning emergency assistance and shall not be routinely muted or silenced. Policy also states that at the beginning of each shift, sworn staff assigned to positions with intercom systems shall check their work area's control panel and ensure intercoms have not been silenced or muted. Garcia did not provide any deputy names and/or dates of the alleged incident. The time span of Garcia's complaint was from the time of his booking on 12-19-22 until he filed this complaint with CLERB on 01-23-23. Throughout this period of five weeks, it was common for the jails to have several deputies on duty as they rotate shifts, conduct mandatory overtime, etc. It was likely Garcia interacted with numerous deputies while housed at SDCJ. Given the lack of information and evidence provided by the complainant, there was insufficient evidence to either prove or disprove the allegation.

2. Misconduct/Procedure – Unidentified deputies "ignored" or "questioned" Garcia's request(s) for grievance forms.

   Board Finding: Not Sustained
   Rationale: The complainant, Andrew Garcia stated he complained to a deputy that there was no hot water in the cell and the deputy said, "Nobody had hot water." Garcia stated he asked the deputy for his attention, and the deputy responded, "What do you want?" Garcia stated he asked for a grievance form and the deputy responded, "What are you trying to grieve about?" Per Title 15, Minimum Standards for Local Detention Facilities, incarcerated persons have the right to file a grievance and forms should be made available to them. According to SDSD P&P Grievance Procedures are established so incarcerated persons have the opportunity for a formal administrative review of issues impacting conditions of confinement which personally affect the incarcerated person. However, written grievances can often be resolved without the intervention of a supervisor, and every effort should be made by a deputy or staff member who receives a grievance to handle it at their level. According to SDSD documentation, the only grievance filed on behalf of Garcia was after the CLERB complaint was submitted. Garcia did not provide any deputy names and/or dates of the alleged incident. The time span of Garcia's complaint was from the time of his booking on 12-19-22 until he filed this complaint with CLERB on 01-23-23. Throughout this period of five weeks, it was common for the jails to have several deputies on duty as they rotated shifts, conducted mandatory overtime, etc. It was likely Garcia interacted with numerous deputies' while he was housed at SDCJ. Given the lack of information and

evidence provided by the complainant, there was insufficient evidence to either prove or disprove the allegation.

3. Misconduct/Procedure – Unidentified deputies served "cold" food to incarcerated persons.

   Board Finding: Not Sustained
   Rationale: The complainant, Andrew Garcia reported deputies placed their meals in the "cold tray box" instead of leaving the food inside the "warmer." Garcia explained that their meals get delivered inside an insulated bag to keep the food warm. Garcia stated deputies would take the food out of the "warmer" and allowed it to sit out for about an hour. Garcia said the food would be served cold and reported, "there was no reason for the deputies to take the food out of the warmer." DSB P&P states that three meals will be served in a 24-hour period and at least one of those meals would include hot food. Food Services Policy does not mention that the food must be served directly from the warmer. Garcia did not provide any deputy names and/or dates for the alleged incident(s). The time span of Garcia's complaint was from the time of his booking on 12-19-22 until he filed this complaint with CLERB on 01-23-23. Throughout this period of five weeks, it was common for the jails to have several deputies on duty as they rotated shifts, conducted mandatory overtime, etc. It was likely Garcia interacted with numerous deputies' while he was housed at SDCJ. Given the lack of information and evidence provided by the complainant, there was insufficient evidence to either prove or disprove the allegation.

4. Misconduct/Procedure – Unidentified deputies delayed Garcia's video visits.

   Board Finding: Unfounded
   Rationale: The complainant, Andrew Garcia reported he was late to the majority of his scheduled video visits due to deputy's being "inconsiderate." Garcia stated he was 25 minutes late to his video visit with his mother. Garcia reported he pressed the intercom to remind deputies of the visit, but he would not get a response. SDSD documentation showed that Garcia attended one scheduled video visit on 01-02-23 from 10:34 am to 10:58 am. The allotted time for video visits is 30 minutes. CLERB contacted the mother, but she was unable to recall if her video visit was delayed with Garcia. There was no evidence that Garcia was 25 minutes late to his video visit. The evidence showed that the alleged act or conduct did not occur.

23-017/TORRES

1. False Arrest – San Diego Police Department Officers arrested Anibal Torres.

   Board Finding: Summary Dismissal
   Rationale: The complainant, Anibal Torres reported "cops" surrounded him on the street, "jumped out and tackled him." Torres stated the "cops" did not provide a reason for his arrest and did not read him his rights. Torres referred to this incident as a "kidnapping." SDSD documentation showed that on 12-05-22, Torres was arrested by Officers with the San Diego Police Department (SDPD) for vehicle theft charges and resisting executive officer. He was subsequently booked into San Diego Central Jail. Pursuant to CLERB Rules & Regulations, Section 4.1: Complaints: Authority, 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. The Review Board lacks jurisdiction.

2. Excessive Force – Deputies 3, 4 and 7 used force toward Torres.

   Board Finding: Action Justified
   Rationale: The complainant, Anibal Torres reported that he was "beat up three times" by deputies. He reported the first time he was "beat up" was because he did not follow deputy orders, so they punched his face/body, "jumped him and broke his nose". According to SDSD documentation, on 12-05-22 Deputies 3,4 and 7 used force towards Torres when they attempted to conduct a routine strip search during the booking process. According to SDSD documentation, Torres pulled his shorts down, bent down, coughed, and said he was not going to do it again. Deputy 3 stated he told him the search was not conducted correctly, but

Torres began to scream profanities. Deputies reported Torres sat on the bench, clasped his unhandcuffed hands together and refused to obey deputy commands. Deputy 4 reported Torres attempted to strike Deputy 3 in the face, so he delivered two closed handed fist strikes to Torres' face. Deputy 3 stated he pulled Torres to the ground, and they ultimately handcuffed him. SDCJ surveillance video was reviewed, but there are no cameras inside of the strip search room. SDSD policy states that, "Deputies shall not intentionally record incarcerated persons while the primary task they are performing involves conducting a strip search…These are confidential settings." SDSD Use of Force policy states that deputies may only use a level of force they reasonable believe is proportional to the seriousness of the suspected offense or the reasonably perceived level of actual or threatened resistance. Subjects must not gain the advantage in a physical confrontation; therefore, deputies may need to use a force option that exceeds the subject's force level. Torres' behavior escalated from passive resistance when he refused to obey deputy commands to assaultive behavior when he attempted to strike a deputy. Deputies used hands-on control techniques to subdue him. Given the totality of circumstances, deputies used a reasonable amount of force to subdue Torres. The evidence showed that the alleged acts did occur but was lawful justified and proper.

3. Misconduct/Harassment - Deputies 1 and 6 (sexually) harassed Torres.

   Board Finding: Not Sustained
   Rationale: The complainant, Anibal Torres reported deputies "sexually harassed" him. Torres stated a deputy told him the following while he conducted a strip search, "Come on take them off, come on show me your ass again." Torres stated he had already showed him, and the deputy wanted to see it again. According to SDSD documentation, on 12-05-22 and 12-08-22 deputies attempted to conduct a routine strip search for contraband, but Torres would not comply. DSB P&P I.52 Strip Search and Pat Down Searches of Incarcerated Persons states that searches of incarcerated persons shall be allowed to control contraband and provide for its disposition. A strip search was defined as, "Any search that requires a person to remove or arrange some or all their clothing to permit visual inspection of the underclothing, breasts, buttocks, genital, or body cavity. A strip search is intrusive in nature, but necessary to control outside contraband from entering the jails. Due to the lack of video or audio recordings for privacy, there was no supporting evidence of the interaction or verbal context between Torres and the deputies during the strip search. Deputies 1 and 6 provided confidential statements which were considered in arriving at the recommended finding. There was insufficient evidence to either prove or disprove the allegation.

4. Excessive Force – Deputies 1, 5 and 6 used force toward Torres.

   Board Finding: Action Justified
   Rationale: The complainant, Anibal Torres reported that he was "beat up three times" by deputies. Torres further stated, "They all rushed me and started to beat me down again." According to SDSD documentation, on 12-08-22, Deputies 1 and 6 used force towards Torres when they attempted (for the second time) to conduct a routine cavity search. Officer reports stated that Deputy 6 instructed Torres to remove his socks and underwear, but Torres stood up from the bench and said, "I'm not doing that gay shit homie." Deputies stated Torres took a fighting stance and did not comply with deputy commands. Deputy 6 stated he drew his Conducted Energy Device (CED/Taser) towards Torres, commanded him to sit down and deputies attempted to handcuff him. Torres then tried to strike a deputy and Deputy 6 struck him in the face area with a closed fist and deputies pulled him down to the floor. According to deputy reports, Torres thrashed his body while he was on the floor and additional deputies responded and ultimately used their CED/Taser towards Torres. Deputies reported that Torres grabbed a deputies taser and pointed it at the deputies, so Deputy 1 delivered hand strikes to Torres' face and was able to regain control of the CED. Deputy 5 stated Torres grabbed his left wrist and pulled the deputy towards him, so the deputy struck him in the face. Torres was tazed by deputies and ultimately handcuffed. SDSD Use of Force policy states that deputies may only use a level of force they reasonable believe is proportional to the seriousness of the suspected offense or the reasonably perceived level of actual or threatened resistance. Subjects must not gain the advantage in a physical confrontation; therefore, deputies may need to use a force option that exceeds the subject's force level. Torres' behavior escalated from passive resistance when he refused to obey deputy commands to assaultive behavior when he attempted to strike/use the taser on a deputy. Torres was evaluated and treated by medical. Although there was no video surveillance available due to privacy, there was no indication of a

policy violation on behalf of the involved deputies. The evidence showed that the alleged acts did occur but was lawful justified and proper.

5. Excessive Force – Deputies 2 and 5 "tased" Torres.

   Board Finding: Action Justified
   Rationale: The complainant, Anibal Torres reported he was tased on his back (by his left underarm) and above his left knee. Torres also stated that the taser fell and he "tased them back out of desperation." According to SDSD documentation, a use of force incident occurred on 12-08-22 where Deputies 2 and 5 used their Conducted Energy Device (CED/Taser) towards Torres when they responded to assist other deputies. Deputy 2 reported deputies struggled to get Torres on the floor, where he thrashed his body and demonstrated assaultive behavior. Deputy 2 reported he drew his CED/Taser and placed it on Torres' right shoulder and drive stunned him. Torres then knocked the CED/Taser out of his hand. Deputy 5 stated he observed Torres' hands on Deputy 2's taser, so he placed both his hands on the back of Torres' head, forced him down to the floor and "pinned" him down for a few seconds. Deputy reports also stated that Torres "tightly wrapped both his legs around Deputy 6's right leg, so Deputy 5 elected to use his CED/Taser to prevent Torres from rolling his body (which would have caused damage to Deputy 6). Deputy 5 deployed one taser cartridge into Torres' upper back and Torres was ultimately handcuffed. SDSD Use of Force policy states that deputies may only use a level of force they reasonable believe is proportional to the seriousness of the suspected offense or the reasonably perceived level of actual or threatened resistance. Subjects must not gain the advantage in a physical confrontation; therefore, deputies may need to use a force option that exceeds the subject's force level. In addition, DSB P&P I.85, Use of Defensive Devices the CED/Taser is authorized to be carried anywhere inside and outside of detention facilities by trained deputies and deputies using such devise shall adhere to departmental use of force guidelines. Deputies attempted to use hands-on control techniques to subdue Torres but were unsuccessful. According to policy, the use of a CED/Taser device is considered Intermediate force, which is defined as less severe than lethal force but capable of inflicting significant pain. There was no surveillance video available due to privacy. Torres was evaluated and cleared by medical. Given the totality of circumstances, deputies used a reasonable amount of force to subdue Torres. The evidence showed that the alleged acts did occur but was lawful justified and proper.

6. Misconduct/Procedure – Unidentified deputies failed to provide Torres with his meals.

   Board Finding: Unfounded
   Rationale: The complainant, Anibal Torres stated he did not receive three daily meals and only received 5-6 meals throughout the 15 days he was incarcerated. He denied that he refused any meals and stated he took the meals deputies gave him. According to SDSD documentation, Torres refused two meals on 12-10-22 because he was on a "hunger strike." Furthermore, documentation showed that Torres refused his meal on 12-12-22 stating, "Hunger strike, hunger strike!" and shook his head when asked if he wanted a meal, and he refused another meal on 12-13-22. Deputies advised Medical staff of the meal refusals. According to an SDSD documentation, Torres ended his "hunger strike" on 12-18-22. The evidence showed that the alleged act or conduct did not occur.

23-025/HUNTER

1. Excessive Force– Deputy 5 used force on Hunter on 01-17-23.

   Board Finding: Not Sustained
   Rationale: Complainant Hunter stated, a "deputy attacked" him in the elevator. Deputy reports stated Hunter entered the elevator, refused to face the wall, and became verbally combative. Deputy 5 attempted to use arm guidance on Hunter in order for him to face the wall, but Hunter pulled away. According to Deputy 1' s report, Hunter "clinched his fists and turned towards" deputies. Deputy 5 grabbed Hunter by the hair and pulled him to the floor. Deputy 1 stated, "I instructed Hunter to place his hands behind his back, but he refused by tucking his arms under his chest. After giving Hunter verbal commands, he attempted to grab onto my left arm." Deputy 1 used a takedown and got Hunter to the floor. Deputy 1 used his department

issued Oleoresin Capsicum (OC) spray and deployed it into Hunter's face. Deputy 1 then delivered two closed fists strikes to his right side of Hunter's head. Deputy 5 was able to secure Hunter in handcuffs. Jail Video Surveillance captured the incident. In the Jail Video Surveillance, Deputy 5 can be seen pointing to the right elevator wall. Hunter is seen standing with his hands in his pants, Deputy 5 grabbed Hunter's arm and Hunter pulled his arm away. Deputy 5 then pushed Hunter against the elevator door and appeared to have his hands on Hunter's right arm. Deputy 1 can be seen unholstering his OC spray as soon as Deputy 5 shoved Hunter against the elevator door. In the jail video Hunter did not appear to "clinch" his fists or turn towards deputies. Due to the location of the deputies and lack of audio, there was no way to determine if Hunter was instructed to put his hands behind his back and/or if he tucked his arms under his chest. There was also no way to determine if Hunter threatened to assault deputies. Hunter appeared non-compliant by moving his arm away from deputies, but there was insufficient evidence to determine if Hunter was assaultive towards deputies. According to SDSD P&P Addendum F Use of Force Policy, "It shall be the policy of this Department that any Deputy Sheriff, in the performance of his/her official law enforcement duties, who has reasonable cause to believe that the person to be arrested has committed a public offense may use objectively reasonable force to effect the arrest, to prevent escape, or to overcome resistance." Deputy 5 provided confidential information during CLERB's investigation that was considered in arriving at the recommended finding. There was insufficient evidence to either prove or disprove the allegation.

2. Excessive Force – Deputy 1 used force on Hunter on 01-17-23.

   Board Finding: Not Sustained
   Rationale: Complainant Hunter stated, a "deputy attacked" him in the elevator. Deputy reports stated Hunter entered the elevator, refused to face the wall, and became verbally combative. Deputy 5 attempted to use arm guidance on Hunter in order for him to face the wall, but Hunter pulled away. According to Deputy 1 report, Hunter "clinched his fists and turned towards" deputies. Deputy 5 grabbed Hunter by the hair and pulled him to the floor. Deputy 1 stated, "I instructed Hunter to place his hands behind his back, but he refused by tucking his arms under his chest. After giving Hunter verbal commands, he attempted to grab onto my left arm." Deputy 1 used a takedown and got Hunter to the floor. Deputy 1 used his department issued Oleoresin Capsicum (OC) spray and deployed it into Hunter's face. 1 then delivered two closed fists strikes to his right side of Hunter's head. Deputy 5 was able to secure Hunter in handcuffs. Jail Video Surveillance captured the incident. In the Jail Video Surveillance, Deputy 5 can be seen pointing to the right elevator wall. Hunter was seen standing with his hands in his pants, Deputy 5 grabbed Hunter's arm and Hunter pulled his arm away. Deputy 5 then pushed Hunter against the elevator door and appeared to have his hands on Hunter's right arm. Deputy 1 can be seen unholstering his OC spray as soon as Deputy 5 shoved Hunter against the elevator door. In the jail video Hunter did not appear to "clinch" his fists or turn towards deputies. Due to the location of the deputies and lack of audio, there was no way to determine if Hunter was instructed to put his hands behind his back and/or if he tucked his arms under his chest. There was also no way to determine if Hunter threatened to assault deputies. Hunter appeared non-compliant by moving his arm away from deputies, but there was insufficient evidence to determine if Hunter was assaultive towards deputies. According to SDSD P&P Addendum F Use of Force Policy, "It shall be the policy of this Department that any Deputy Sheriff, in the performance of his/her official law enforcement duties, who has reasonable cause to believe that the person to be arrested has committed a public offense may use objectively reasonable force to effect the arrest, to prevent escape, or to overcome resistance." Deputy 1 provided confidential information during CLERB's investigation that was considered in arriving at the recommended finding. Deputy statements provided during administrative investigations are deemed confidential by law and cannot be publicly disclosed. CLERB requested an interview with Deputy 1 on 09-28-23, the response is still pending as of 10-06-23. There was insufficient evidence to either prove or disprove the allegation.

3. Excessive Force- Deputy 1 deployed Oleoresin Capsicum (OC) spray on Hunter's face.

   Board Finding: Not Sustained
   Rationale: Complainant Hunter stated, a "deputy attacked" him in the elevator. *See Rationale 1.* According to Use of Force Policy, "Department issued Oleoresin Capsicum (OC) spray and irritant filled projectiles are the only chemical agents to be carried and utilized by authorized department personnel, with the exception

of agents deployed by SED." Furthermore, the policy states "chemical agents may be used when **there is an immediate threat to safety of the deputy** or others; **AND** either the offense committed is sufficiently severe to justify the use of intermediate force; or the suspect is **actively resisting arrest**; or attempting to flee. The policy states "OC is used to subdue subjects by spraying the agent onto the face. In order to be effective, the active ingredient must come in contact with the eyes and mouth. The spray should not be aimed directly at the eyes. The force of the stream leaving the projector could damage the soft tissue of the eye. The agent should be just as effective if the bridge of the nose or the chin is targeted. OC may not be effective from less than three feet." It is the responsibility of the deputy deploying chemical agents to ensure that appropriate decontamination measures are undertaken as soon as practical after application. The policy states, "the subject should be handcuffed prior to decontamination because the duration of incapacitation will vary depending upon the type of agent used and the individual's reaction to the agent. Avoid placing the subject in a prone position any longer than necessary to complete the handcuffing process." SDSD DSB P&P I.85 titled, "Use of Defensive Devices" authorizes the use of OC spray. SDSD records showed Deputy 1 completed Chemical Agents trainings on 08-15-22. CLERB requested an interview with Deputy 1 on 09-28-23, the response is still pending as of 10-06-23. There was insufficient evidence to determine an immediate threat to safety of the deputy and an active resistance to arrest.

4. Misconduct/Procedure – Deputy 12 failed to keep Hunter in the recovery position.

   Board Finding: Not Sustained
   Rationale: In the course of investigation, it was discovered Hunter was placed in the prone position on the gurney. Jail Video Surveillance showed Hunter in and out of the prone position after the incident, and while he was receiving medical treatment. Per SDSD DSB P&P M.32 titled "Use of Medical Gurney", states "Incarcerated Person (IP) shall, as soon as practical, be transitioned to an upright seated position or on their side in the recovery position." The policy also states, "prolonged retention or transporting of an IP on a gurney in the prone position is prohibited unless deemed clinically necessary by health staff." The policy states, "Placing an IP in the prone position on a gurney may be done for only the minimal time necessary to effectively gain physical control and, if not yet completed, secure them in handcuffs/waist chains or a maximum restraint device." The policy states anytime an IP is placed on a gurney by sworn staff, one deputy shall be designated as the "safety deputy". The safety deputy's sole responsibility is to continually monitor the health and safety of the IP for signs of distress (e.g., compromised breathing, changes in level of consciousness). According to SDSD records, Deputy 12 was designated as the Safety Deputy. Jail Video Surveillance showed Hunter was placed in a prone position on the gurney and transported to jail medical. Once in medical, Hunter can be seen continuously in and out of the prone position. Due to camera location, and deputies positioning in front of camera, CLERB was unable to determine the number of times Hunter was readjusted to the recovery position by Deputy 12 and/or if Hunter was able to move to recovery position on his own accord. According to deputy reports, Hunter was on the medical gurney for approximately 27 minutes. Deputy 12 provided confidential information during CLERB's investigation that was considered in arriving at the recommended finding. Deputy statements provided during administrative investigations are deemed confidential by law and cannot be publicly disclosed. There was insufficient evidence to prove or disprove the allegation.

5. Misconduct/Medical - Medical Staff did not provide Hunter proper medical care.

   Board Finding: Summary Dismissal
   Rationale: Complainant Hunter stated, "I requested to be taken to the hospital to be seen by a professional and she told me she would check on me and never did." SDSD Jail Medical Records showed Hunter was immediately seen following the use of force by Jail Medical staff on 01-17-23. SDSD Medical notes indicated no trauma or injuries were seen or reported. The notes also indicated a Qualified Medical Health Professional (QMHP) was called for evaluation and Hunter would be scheduled for a follow up. According to SDSD Medical notes Hunter refused to participate in a medical evaluation in his cell on the following day. As per DSB P&P M.15, entitled "Sick Call", Inmates shall have access to appropriate medical and mental health services on a daily basis. Furthermore, Hunter stated a nurse attempted to "cover up the deputys wrongdoings [sic]". Hunter also stated Medical refused to see him on 01-26-23. CLERB lacks jurisdiction to investigate the complaint, 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. CLERB has no jurisdiction over medical personnel. The review board lacks jurisdiction.

6. Misconduct/Procedure – Unidentified nurse "covered-up" deputy misconduct.

   Board Finding: Summary Dismissal
   Rationale: Complainant Hunter stated a nurse attempted to "cover up the deputys wrongdoings [sic]". CLERB lacks jurisdiction to investigate the complaint, 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. CLERB has no jurisdiction over medical personnel. The review board lacks jurisdiction.

7. Misconduct/Procedure – Unidentified deputy refused to take Hunter to medical.

   Board Finding: Unfounded
   Rationale: Complainant Hunter stated, "Deputy also have been refusing medical attention since the incident on 01-17-23." Per DSB P&P M.15, entitled "Sick Call", Inmates shall have access to appropriate medical and mental health services on a daily basis. SDSD jail medical records showed Hunter was seen by Jail Medical on 01-17-23, 01-18-23, 01-19-23,01-23-23, and 01-25-23. The evidence showed the act or conduct did not occur.

8. Misconduct/Medical - Medical staff refused to see Hunter.

   Board Finding: Summary Dismissal
   Rationale: Complainant Hunter stated Medical refused to see him on 01-26-23. CLERB lacks jurisdiction to investigate the complaint, 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. CLERB has no jurisdiction over medical personnel. The review board lacks jurisdiction.

9. Misconduct/Procedure – Deputies 4 and 9 refused Hunter medical attention.

   Board Finding: Unfounded
   Rationale: Complainant Hunter stated, on 01-26-23 around 12:00-1:00PM, "Deputies also refused to answer the medical button when I was being held in solitary confinement. I notified deputies 4 and 9 and was laughed at and was told if I hit the button, I am not having a seizure." As per DSB P&P M.15, entitled "Sick Call", Inmates shall have access to appropriate medical and mental health services on a daily basis. the holding cells, nor do they record audio. As such, it was unknown what deputies communicated to Hunter. Furthermore, DSB P&P Section M.1, titled "Access to Care", establishes guidelines for reasonably prompt access to medical services for any inmate complaining of illness or injury. The policy explains that any IP in the custody of the San Diego Sheriff shall have quality and timely access to care for their medical needs. Inmates must have access to health care services free from unreasonable barriers that deter them from seeking care for their health needs. SDSD records produced an incident report written by Deputy 9 on 01-27-23. Deputy 9 stated Hunter told him he was having a seizure. In an effort to ensure Hunter was medically taken care of, Deputy 9 notified the 3rd Floor Clinics area and requested a medical professional evaluate Hunter. According to the incident report, Hunter refused to comply with instructions given by nursing staff and spoke disrespectful to deputies and medical staff. According to the incident report, medical staff evaluated Hunter and he was cleared to remain in his cell. SDSD Medical records confirmed Hunter was seen by medical staff on housing floor for complaints of "seizure and heart attack". All medical documentation corroborated Deputy 9' incident report. Medical documentation showed Hunter was seen at 12:46PM by medical staff. Deputy 9 incident report was entered at 1:17PM on 01-27-23. The evidence showed the incident occurred on 01-27-23, not 01-26-23 and Hunter was seen by medical staff. Furthermore, the

evidence showed Hunter was argumentative and did not follow instructions of both medical staff and deputies.

10. Misconduct/Procedure – Deputies 6, 10, and an Unidentified Watch Commander did not respond to Hunter's callbox.

    Board Finding: Unfounded
    Rationale: Complainant Hunter stated, "Deputies also refused to answer the medical button when I was being held in solitary confinement." According to Hunter on 02-12-23 he "repeatedly" hit the callbox button to alert staff of his medical emergency, but no one answered until he passed out. Hunter identified Deputies 6, 10, 11. According to SDSD P&P Section I.2, Intercom Systems are accessible to inmates to provide a means of communication between inmates and sworn staff. Intercom systems should be primarily used as a means of relaying and or summoning emergency assistance. Intercoms shall not be routinely muted or silenced. In the event of an emergency or incident, an IP is to depress the intercom call button which activates an alarm on the receiving end. The alarm will alert sworn staff of a possible emergency or incident that necessitates their attention. Sworn staff will answer all intercom calls in an expeditious manner and follow-up on the nature of the call. Though numerous jail surveillance video recordings were reviewed, it was noted none of the jail surveillance video recordings illustrate the interior of the holding cells, nor do they record audio. As such, it was unknown what deputies communicated to Hunter. SDSD DSB P&P Section M.5 titled Medical Emergencies is to provide guidelines for deputies in their response to medical emergencies. The policy directs that 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 SDSD records, Hunter also submitted a grievance alleging deputies' failure to respond to callbox. In the grievance response, a Sergeant responded and stated they spoke with the deputies working the prior evening and stated "the deputy working the tower that night said he responded when you called on the intercom around 10:00PM. When asked how he could be of assistance, he only heard laughter in the background. The tower deputy said he informed the deputies working the floor that he had received a call from cell via the intercom but only heard laughter and requested they check your cell. One deputy said, prior to entering the module to conduct the welfare check, they saw you standing at the cell door looking out the cell door window. When they entered the cell, you were lying on your assigned bunk with no signs of distress. This happened two more times in the night, according to the three deputies I spoke to. The deputy working the tower said they kept the intercom to your cell on from approximately 10:00PM to 1:00AM. The tower deputy said for most of the night, you and your cellmate were talking normally until you both fell asleep 01:00AM." The evidence shows that the alleged act or conduct did not occur.

11. Misconduct/Procedure - Deputies 6 and 10 failed to provide medical attention.

    Board Finding: Unfounded
    Rationale: Complainant Hunter stated, Deputies 6 and 10 "failed to provide medical attention while having a seizure on 02-12-23 at 10PM". *See Rationale 10.*

12. Misconduct/Discourtesy – Unidentified deputies asked unprofessional questions through Hunter's callbox.

    Board Finding: Not Sustained
    Rationale: Complainant Hunter also stated, his cellmate told him the Watch Commander asked unprofessional question through their callbox. Per SDSD P&P Section I.2, Intercom Systems are accessible to inmates to provide a means of communication between inmates and sworn staff. SDSD P&P 2.22 titled, "Courtesy" states, "Employees shall be courteous to the public and fellow employees. They shall be tactful in the performance of their duties, shall control their tempers, exercise patience and discretion even in the face of extreme provocation. Coarse, profane, or violent language is generally prohibited. Employees shall not use insolent language or gestures in the performance of his or her duties." According to SDSD records, Hunter's cellmate was identified as Johnza Watson. Watson is in custody at Wasco State Prison. CLERB attempted to contact Watson at Wasco, but Watson did not respond. Furthermore, Intercom Systems in San

Diego County Jails do not currently record audio. Due to the lack of evidence CLERB was unable to investigate further to prove or disprove the allegation.

13. Misconduct/Intimidation – Deputies 4 and 9 threatened Hunter with force.

    Board Finding: Action Justified
    Rationale: Complainant Hunter stated, on 01-26-23, "Deputies 4 and 9 also came to my cell in solitary confinement after an hour of refusing medical attention and threatened to use force if didn't hurry up and get my things." According to the Addendum F-Use of Force Policy, "the preservation of order and the observance of law are best achieved through voluntary compliance rather than force or compulsion". Furthermore, the policy defines De-escalation as "actions taken in an attempt to stabilize an incident in order to try and reduce the immediacy of a threat by obtaining more time, tactical options or resources to resolve an incident. The goal of de-escalation is to gain voluntary compliance of subjects, when feasible, and or to potentially reduce or eliminate the need to use force on a subject." De-escalation techniques include "communicating with a subject from a safe position using the following compliance techniques: verbal persuasions, advertisements, and warnings." The complainant provided no further information to support this allegation and the context was unknown due to an alleged and unrecorded conversation. Policy allows for verbal warnings in order to gain voluntary compliance from IPs. The evidence shows that the alleged act or conduct was lawful, justified and proper.

14. Misconduct/Procedure - Unidentified deputies failed to provide Hunter shower access.

    Board Finding: **Sustained**
    Rationale: Complainant Hunter stated he has been "held in an unsanitary cell without being able to shower for a week and sergeants have done nothing about it." Per SDSD DSB P&P L.11 entitled "Personal Hygiene", Upon assignment to a housing unit an inmate will be allowed a shower and additional showers at least every 48 hours thereafter. As per Title 15, 1266. "Showering. There shall be written policies and procedures developed by the facility administrator for inmate showering/bathing. Inmates shall be permitted to shower/bathe upon assignment to a housing unit and at least every other day or more often if possible." As per SDCJ Post Orders, the Housing Deputy is responsible for ensuring all inmates are given the opportunity to shower at least every 48 hours. If the inmate refuses, it must be logged in JIMS and the Floor Sergeant must be notified. In an effort to improve transparency and Title 15 law compliance, in CLERB case #21-083/Park, CLERB recommended the completion or incompletion (and reason for incompletion) of all California Title 15 Minimum Standards for Local Detention Facilities requirements shall be noted in JIMS (showers, mail, etc.). On 12-28-22, SDSD responded and stated, "Although Title 15 requirements, such as meals and showers, are facilitated by staff, it is incumbent upon the IP to assume the responsibility of eating, showering, etc." Furthermore, in SDSD's response it was stated "There is also no requirement under Title 15, which mandates the documentation of these activities. However, this recommendation is already a current operational practice for the San Diego Sheriff's Department." Current policy only requires shower refusals to be logged, **however, there was sufficient evidence that 48 hours elapsed between Hunter being permitted to shower.**

15. Misconduct/Procedure - Deputies 2, 3, 7 and 8 refused to resolve issues of cruel and unusual punishment.

    Board Finding: Not Sustained
    Rationale: Complainant Hunter stated, "Sergeants that failed to resolve issues of cruel and unusual punishment and with other deputys: 2,3,7, and 8". Hunter stated in his complaint, he was "held in an unsanitary cell without being able to shower for a week and Sergeants have done nothing about it." SDSD records showed Hunter filed a grievance complaint regarding "police brutality" and "inhumane conditions" on 01-17-23, which was responded to by a Sergeant. The response indicated Hunter complained of "police brutality" and "inhumane conditions" due to the use of force on 01-17-23. Furthermore, the response stated on 02-13-23, staff found pruno in Hunter's cell, which "the process is prone to formation of toxins". SDSD also investigated other claims in this grievance such as medical allegations (that are also outlined in this report). SDSD records showed Deputy 7 addressed a Grievance submitted by Hunter regarding "medical attention" and responded in a Grievance Report on 01-26-23. *See Rationale #12 for further information*

regarding shower access allegation. Without further clarifying information, the complaint was too vague to investigate further. There was insufficient evidence to prove or disprove the allegation.

16. Misconduct/Procedure – Unidentified deputies placed Hunter into an "unsanitary" cell.

    Board Finding: Summary Dismissal
    Rationale: Complainant Hunter stated is "being held in an unsanitary cell". SDSD DSB P&P L.4 titled "Housekeeping Plan", establishes a policy to ensure a written housekeeping plan exists for each facility. According to the policy, the facility green sheet outlines the housekeeping plan for SDCJ. According to the Green Sheet for SDCJ, "the facility worker deputy will provide a crew of facility workers to accomplish the daily cleaning schedule of the facility." Facility workers are non-sworn personnel and as such CLERB lacks jurisdiction. The review board lacks jurisdiction.

17. Misconduct/Procedure - Internal Affairs (IA) did not respond to Hunter.

    Board Finding: Summary Dismissal
    Rationale: Complainant Hunter stated, "I have sent IA multiple letters in an attempt to resolve these problems with no response." SDSD P&P 3.2 titled "Complaints Against Sheriff's Employees", states "The Sheriff's Department will accept complaints of inadequate service or alleged employee misconduct and process those complaints according to procedure. Complaint investigations shall be conducted in a fair, thorough, impartial, and timely manner." Due to the confidentiality of personnel files, investigation details are out of CLERB's purview. According to an email from Division of Inspectional Services, the SDSD has received multiple Internal Affairs (IA) complaints from Hunter and some family members. All complaints are currently being investigated or have been closed. The Review Board lacks authority to investigate further.

18. Misconduct/Procedure - Unidentified deputies refused to provide complaint forms.

    Board Finding: Unfounded
    Rationale: Complainant Hunter stated, "I am writing this complaint on paper because deputys and sergeants have refused to give me the complaint forms on multiple attempts." SDSD DSB P&P N.3 entitled, "Inmate Request Forms" established a procedure for the expeditious resolution of inmate requests. As per the SDCJ Post Orders, Housing Deputy duties include "Ensure all inmate requests and grievances are answered quickly and/or directed to the proper person for response to that request." However, the post orders do not include who is responsible for refilling forms. In an email from CLERB liaison Sergeant Tingley, he stated the facility stock clerk or storekeeper stocks the grievances for the deputies or staff to distribute. SDSD records had no indication that that Hunter requested an Inmate Request Form and/or made any verbal complaints of no forms. SDSD records produced grievances submitted by Hunter on 01-20-23, 02-02-23, 02-03-23, 03-30-23, and an undated grievance which was marked received on 02-12-23. There is currently no policy in place that mandates SDSD to give IPs access to CLERB complaint packets. To improve transparency and give IPs the opportunity to write to CLERB, it is recommended SDSD create a policy ensuring IPs have access to CLERB complaint packets. Due to the lack of policy creating access to CLERB complaint packets, and the evidence that exists for grievances received, there was no evidence of misconduct against sworn personnel. Furthermore, facility stock clerks and storekeepers are non-sworn staff and as such CLERB lacks jurisdiction.

POLICY RECOMMENDATIONS:

1. It is recommended the San Diego Sheriff's Department (SDSD) mandate the logging of shower access when an Incarcerated Person (IP) is in lockdown.

2. It is recommended the SDSD create a policy to ensure IPs have access to CLERB complaint packets.

23-036/APAN & SOWLE

1. Misconduct/Procedure– Unidentified deputies housed Apan in administration separation.

   Board Finding: Action Justified
   Rationale: Complainant Apan stated, “On 03-15-23, they transfer me from general population to administrative separation (ad-seg) here in SDCJ 4F cell 2. I’ve asked multiple deps, corps, and sergeants for the reason of the ad-seg. I have been here 4 weeks now still waiting for the answer. I have no major writes since Sept ’21”. SDSD records showed Apan was placed in administrative separation on 03-15-23. Per SDSD DSB P&P J.3, “Administrative separation shall consist of separate and secure housing, but shall not involve any other deprivation of privileges, other than is necessary to obtain the objective of protecting the Incarcerated Person, staff, or public.” Per policy, Incarcerated Persons may be placed in administrative separation, “Those who demonstrate influence over other Incarcerated Persons, including influence to promote or direct action or behavior that is criminal or disruptive to the safety and security of other Incarcerated Persons and/or facility staff, as well as to the safe operation of the facility. SDSD records showed administration separation was documented and valid in accordance with policy. SDSD records produced a Jail Information Management System (JIMS) incident report, and a separation Housing Order J-72 in accordance with policy. The evidence showed that the alleged act or conduct did occur but lawful, justified, and proper.

2. Misconduct/Procedure – SDSD failed to address roach infestation.

   Board Finding: Summary Dismissal
   Rationale: Co-complainant Sowle stated, “his (Apan’s) commissary food is now infested with baby roaches, he has been complaining about roaches there but not one person has done anything about any of this.” Apan stated, “since living in this cell I have informed sergeants and deps every shift there’s a roach infestation here and I have them in my commissary, property backs, and clothes.” Per SDSD DSB P&P L.13, “Each facility's written plan will include monthly inspections by staff to locate and identify areas of infestation. If located, staff should identify the conditions to include the presence of insects, rodents, or other vermin. This information should be communicated to the County of San Diego Department of Agricultures, Weights and Measures, Pest Detection Program, and a request for eradication should be made. Once scheduled, a technician will arrive and determine the best method for eliminating the nuisance.” Per SDCJ Green Sheet L.13.C.1, “Monthly vermin and pest control inspections will be conducted by licensed (County/Contracted) professionals or appropriately trained staff. Any identified conditions, including the presence of insects, rodents, or vermin, shall be eradicated under the direction of the Integrated Pest Control Program with the Department of Agriculture, Weights and Measures. All requests for pest control service outside of the monthly inspections will be submitted to the operations deputy. The operations deputy will make notifications and coordinate any additional services.” Per an email from CLERB Liaison, Sergeant Bracy, “Vector Control does routinely visit the facility for pest eradication”, however this is not something that is tracked or archived. SDSD records showed no record of roach infestation complaints submitted by Apan. Policy dictates non-sworn personnel are responsible for the monthly inspections, and any requests beyond the monthly inspection be coordinated by the operations deputy. Ultimately pest and venom control management tasks are performed by facility staff and as such CLERB lacks jurisdiction to investigate further. The Review Board lacks jurisdiction.

3. Misconduct/Procedure – Unidentified deputies refused Apan’s Inmate Grievances.

   Board Finding: Not Sustained
   Rationale: Complainant Apan stated, “they refused 3 grievances on the bug infestation saying its not grievable. Its maintenance thing.” According to SDSD DSB P&P N.1 titled “Grievance Procedure”, states Incarcerated Persons may use the grievance procedure for complaints related to any aspect of condition of confinement that directly and personally affects the Incarcerated Person grievance. The policy states, this incudes food, clothing, and bedding. SDSD records produced no grievances from Apan regarding bug infestation. There was insufficient evidence to prove or disprove sworn this allegation.

4. Misconduct/Procedure – Unidentified staff denied Apan social visits.

Board Finding: Summary Dismissal
Rationale: Complainant Sowle stated Apan has not had any visits in 16 days. Sowle, stated "zero video visits in 16 days". Apan stated, "admin tells family members I am not on schedule for visits and will call back when they figure it out. I've been waiting to see my family for 4 weeks now. I am not on discipline". Title 15 Guidelines states, "Visits may not be cancelled unless a legitimate operational or safety and security concern exists. All cancelled visits must be documented. The facility manager or designee shall regularly review cancelled visits and document such review." SDSD DSB P&P P.9 titled, "Social visiting", establishes guidelines for permitting Incarcerated Persons social visits. Per the policy, social visits and video visitations are a privilege, and as such, (at the discretion of the Watch Commander) may be suspended as part of a disciplinary action. Furthermore, the policy states the Watch Commander may temporarily suspend facility visits in the event of any emergency that threatens the safety and security of the facility. The policy also states, "The Watch Commander will resolve questions regarding the eligibility for either the Incarcerated Person or visitor." SDSD records showed no record of visitation suspension for Apan. The Watch Commander log showed all social and video visits were cancelled on 03-31-23. Apan's Inmate History Summary Report notated on 03-15-23 "deleted future visits because of facility transfer". SDSD records showed Apan transferred from GBDF to SDCJ on 03-15-23. According to information provided by Division of Inspectional Services, the deleted future visits only applied to visits requested while Apan was housed at GBDF and should not have affected his ability to have visits after this transfer. SDSD records showed Apan had social visits 03-04-23 and 03-11-23, a special visit on 4-13-23 then deleted visit. SDSD records also showed four special visits on 04-14-23. According to information received from the Division of Inspectional Services, the department does not keep track of attempts to schedule visits from family members, and only records when a visit is successfully scheduled. SDSD DSB P&P P.9 states Detention Information Assistants (DIAs) are responsible for the scheduling of social visits. While the evidence suggest Apan did not have social visits for four weeks, the scheduling of visits are the responsibility of DIAs. DIAs are non-sworn personnel and as such CLERB has no jurisdiction. The Review Board lacks jurisdiction.

5. Misconduct/Procedure – Unidentified deputies denied Apan haircuts and nail clippers.

Board Finding: Action Justified
Rationale: Complainant Apan stated, "they refuse to give me social visits, haircuts, nail clippers, laundry depending on the night crew." Per SDSD DSB P&P L.9 titled "Haircuts/Hair Care" states, "Incarcerated Persons shall have access to a barber while incarcerated. The barber and equipment will be available on a regularly scheduled basis." According to the policy, "a designated incarcerated worker/barber, if available shall perform haircuts for I/Ps." The policy also states, "Deputies will make a JIMS log entry indicating the module that received haircuts". The Facility Green Sheet for SDCJ, L.9.C1 states the haircuts for Apan's module occur on Mondays. According to the Facility Green Sheet, nail clippers are made available to the Incarcerated Persons while haircuts are being given. Deputies are responsible for inventorying and inspecting the barber tools and providing security during haircuts. Furthermore, the SDCJ Post Orders for Housing Deputy states, "Ensure all scheduled events (hygiene inspections, haircuts, commissary, etc.) are conducted according to approved schedules and procedures and completed in a timely manner." According to Title 15 Minimum Standards, "Hair Care services shall be available" and IPs should be allowed to receive hair care services at least once a month". SDSD records produced the area activities summary report for Apan's module on 03-15-23 to 04-15-23. showed haircuts were offered in Apan's housing module on 04-03-23. SDSD records showed haircuts did not occur in Apan's module 03-20-23 due to "unavailable". Also, haircuts did not occur 03-27-23 and 03-28-23 due to staffing shortages. While the policy defines a regularly scheduled basis as weekly, haircuts are only required to be offered monthly per Title 15 guidelines, as such there was no violation of policy.

6. Misconduct/Procedure – Unidentified deputies denied Apan laundry service.

Board Finding: Sustained
Rationale: Complainant Apan stated, "they refuse to give me social visits, haircuts, nail clippers, laundry depending on the night crew." Complainant Sowle stated, "laundry exchanges are few in between". SDSD DSB P&P L.1 titled "Laundry Schedule", establishes guidelines for laundry exchange. Per policy, socks, undergarments and t-shirts are exchanged once a week. Blanket exchanges occur on a bi-weekly (once

every two weeks) basis. Each facility develops laundry procedures on a facility green sheet. According to the facility green sheet for SDCJ, laundry schedule is weekly and blanket exchanges every 2 weeks. Title 15 Guidelines regarding Clothing Exchange state, “Unless work, climatic conditions, illness, or California Retail Food Code necessitates more frequent exchange, outergarments, except footwear, shall be exchanged at least once each week. Undergarments and socks shall be exchanged twice each week.” According to L.1, “A Jail Information Management System (JIMS) "Laundry Exchange" log entry will be made to record each exchange. The type of exchange (e.g. "Blankets") will be noted in the "Description" field of the log entry. In the event an item is unavailable for the laundry exchange, the deputy of the affected area shall document which item was not exchanged in the "Notes" section of the log entry.” The SDCJ Post Orders for Housing Deputy state, “Facilitate laundry exchange according to the laundry schedule. A JIMS log entry will note the items being exchanged.” SDSD records showed Laundry exchange occurred in Apan’s module on 03-17-23, 03-30-23, 04-15-23. SDSD records showed Laundry Exchange did not occur on 03-24-23 due to staffing shortage and 04-14-23 due to a cell search and staffing shortage. None of the JIMS entries notated the type of exchange in “notes” or “description”. The evidence showed laundry exchange did not occur on a weekly basis in accordance with SDSD policy and Title 15-Minimum Standards for Adult Facilities by BSCC California. The evidence supports the allegation and the act or conduct was not justified.

7. Misconduct/Procedure – Unidentified deputies did not log laundry exchange.

   Board Finding: Sustained
   Rationale: Through the course of investigation, it was determined laundry exchanges were not properly logged in accordance with policy. SDSD DSB P&P L.1 titled “Laundry Schedule”, establishes guidelines for laundry exchange. Per policy, socks, undergarments and t-shirts are exchanged once a week. Blanket exchanges occur on a bi-weekly (once every two weeks) basis. Each facility develops laundry procedures on a facility green sheet. According to the facility green sheet for SDCJ, laundry schedule is weekly and blanket exchanges every 2 weeks. Title 15 Guidelines regarding Clothing Exchange state, “Unless work, climatic conditions, illness, or California Retail Food Code necessitates more frequent exchange, outergarments, except footwear, shall be exchanged at least once each week. Undergarments and socks shall be exchanged twice each week.” According to L.1, “A Jail Information Management System (JIMS) "Laundry Exchange" log entry will be made to record each exchange. The type of exchange (e.g. "Blankets") will be noted in the "Description" field of the log entry. In the event an item is unavailable for the laundry exchange, the deputy of the affected area shall document which item was not exchanged in the "Notes" section of the log entry.” The SDCJ Post Orders for Housing Deputy state, “Facilitate laundry exchange according to the laundry schedule. A JIMS log entry will note the items being exchanged.” SDSD records showed laundry exchange occurred in Apan’s module on 03-17-23, 03-30-23, 04-15-23. SDSD records showed Laundry Exchange did not occur on 03-24-23 due to staffing shortage and 04-14-23 due to a cell search and staffing shortage. None of the JIMS entries notated the type of exchange in “notes” or “description” as required by policy. The evidence supports the allegation and the act or conduct was not justified.

8. Misconduct/Procedure – Unidentified deputies and/or inmate workers refused to collect trash.

   Board Finding: Summary Dismissal
   Rationale: Complainant Sowle stated, “just trying to get someone to take the trash out of there is next to impossible”. Per SDSD DSB P&P L.5 titled, “trash removal” states, “a deputy will supervise inmate workers who will pick up and transport all trash to the collection area for disposal.” CLERB attempted to contact Sowle to get further information about this allegation but was unsuccessful. CLERB was unable to determine if the allegation was against inmate workers or sworn personnel and as such could not investigate further. The Review Board lacks jurisdiction or the complaint clearly lacks merit.

9. Misconduct/Procedure – Unidentified deputies denied Apan Recreation Yard time.

   Board Finding: Sustained
   Rationale: Complainant Sowle stated, “no yard time in 16 days.” Apan stated, “I have been out of the cell 1 time to yard April 1.” Title 15 guidelines states, “The facility administrator of a Type II or III facility shall

develop written policies and procedures for an exercise and recreation program, in an area designed for recreation, which will allow a minimum of three hours of exercise distributed over a period of seven days". Per SDSD DSB P&P T.11 titled "Exercise and Recreation", states "An exercise and recreation program shall be available to Incarcerated Persons at each facility. It shall afford the Incarcerated Person an opportunity to utilize an area designed for recreation. It shall include a minimum of two (2) exercise periods, and a minimum of three (3) hours per week, per Incarcerated Person." As reported above, Apan was placed in administration separation on 03-15-23. Furthermore, SDSD DSB P&P T.11, states for administratively separated Incarcerated Persons, "a JIMS entry will be made in the Incarcerated Person's history using the "REC YARD STARTED" drop-down to indicate when the Incarcerated Persons have been given access to the recreation yard. Another JIMS entry will be made using the "REC YARD ENDED" drop-down in the Incarcerated Person's history to indicate when the Incarcerated Person has been returned to their housing unit. If an Incarcerated Person chooses not to utilize the recreation yard, an entry will made in the Incarcerated Person's history by using the "REC YARD REFUSED" drop-down in JIMS. If there are circumstances that preclude the Incarcerated Person from utilizing the recreation yard during the scheduled time (i.e. - inclement weather, maintenance issues, facility emergency, etc.), an entry will be made in the Incarcerated Person's history in JIMS. Using the "REC YARD UNAVAILABLE" drop-down, the deputy will describe why the recreation yard was not available. If necessary, the "Notes" area may be used to provide a detailed explanation." SDSD records showed from 03-11-23 to 04-15-23, Apan had one status change to "RECS" on 04-01-23 at 9:26PM. There were no documented rec yard refusals during this period and no documented rec yard unavailable in Apan's Inmate history. According to information received from Division of Inspectional Services, "Logged documentation for Apan's Exercise and Recreation time has been minimal". Furthermore, "anytime he is being offered dayroom or rec-yard it should be logged in his history (even if he refuses). I'm not saying that always occurs but that is what deputies should be doing by policy." Furthermore, Division of Inspectional Services stated they were unaware of any restrictions on Apan's rec-yard or social visits beyond those which apply to all inmates. Division of Inspectional Services stated, "there is no dayroom available that would remain separated from other inmates, so Apan would need to do all his out-of-cell time, whether dayroom or rec-yard, in the rec-yard designated for those inmates." SDSD records indicated no dayroom use either. The evidence supports the allegation and the act or conduct was not justified.

10. Misconduct/Procedure – Unidentified deputies delayed mail.

    Board Finding: Action Justified
    Rationale: Complainant Apan stated, "also mail takes a while to get here. I've been waiting for emails, they take up to a week since I've been in this mod/cell." Per SDSD DSB P&P P.3 titled "Incarcerated Person Mail", states," Deputies assigned to the Mail Processing Center and Sheriff's Transportation Detail (STD) will work collaboratively with detention facilities' staff to provide the reasonably prompt delivery of incoming materials." SDSD records showed on 03-24-23, an incident report was written which required Apan's mail to be monitored due to serious crime and/or illicit activity. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

11. Misconduct/Medical – SDCJ medical staff failed to provide medical care to Apan.

    Board Finding: Summary Dismissal
    Rationale: Complainant Apan stated, "I woke up with a bug bite on my lower back today. I informed medical same day and they gave me pills but didn't properly inspect the wound." Complainant Sowle stated, Apan "had to go without his medication for almost 4 days because everyone told him to hold on and never came back." Per DSB P&P M.15, entitled "Sick Call", Inmates shall have access to appropriate medical and mental health services on a daily basis. CLERB lacks jurisdiction to investigate the complaint, 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. CLERB has no jurisdiction over medical personnel. The review board lacks jurisdiction.

12. Misconduct/Procedure – SDSD facilities have poor jail conditions.

Board Finding: Summary Dismissal
Rationale: Complainant Sowle stated, “I suggest these matters be addressed and staff and not only this facility, but your other facilities as well get a grip on how many inmates are being treated because I’m making this personal goal of mine to shed light to this unfortunate event, in which I find it very hard to believe that this is an isolated event. I hope that this complaint is not taken lightly because if it was your loved ones biting into food with roaches in it or surrounded by people who are choosing to treat you as if you have no rights or as if you are not human I’m sure you wouldn’t be happy either I will make this situation have mounds of attention because this is not only illegal but wrong. Your facilities have signs with rights listed but yet you guys cant follow them.” CLERB attempted to contact Complainant Sowle to get further information about this allegation but was unsuccessful. The Review Board lacks jurisdiction or the complaint clearly lacks merit.

23-053/DANIELS

1. Misconduct/Discourtesy – Deputy 1 stated, “fuck your mattress, I just saved you from 1-C you little bitch.”

   Board Finding: Not Sustained
   Rationale: Complainant James Daniels stated, “I was taken by (Deputy 1)… to unit 1-A… (upon) arrival I had no mattress to sleep on. So I asked (Deputy 1) for one… I told him I would write him up if not provided a (mattress) to sleep on, to which he became enraged (and) said ‘fuck your mattress, I just saved you from 1-C you little bitch.” According to SDSD documents received related to this incident, on 05-10-23, I/P Daniels, who was in custody at George Bailey Detention Facility (GBDF), was moved from House 1, Module C, to House 1, Module A. SDSD Policies and Procedures (P&P) Section 2.22, Courtesy, stated, “Employees shall be courteous to the public and fellow employees. They shall be tactful in the performance of their duties, shall control their tempers, exercise patience and discretion even in the face of extreme provocation. Coarse, profane, or violent language is generally prohibited. Employees shall not use insolent language or gestures in the performance of his or her duties.” Given this incident occurred at George Bailey Detention Facility (GBDF), there was no audio recording of this interaction. Considered as evidence related to this finding were confidential statements made by Deputy 1 in a Sheriff Employee Response Form (SERF).” There was insufficient evidence to either prove or disprove the allegation.

2. Misconduct/Procedure – Deputy 1 “threw” a mattress at incarcerated person James Daniels.

   Board Finding: Not Sustained
   Rationale: Daniels stated, “I was (assaulted) by GBDF… (Deputy 1)… he enters 1-A almost at a jogging pace enters my pod (and) throws the worst ripped mattress he could find in my face from 3 to 4 feet away from me, to which the ripped nylon cut/abrasioned my right check.” CCTV footage related to this incident did not assist in making a finding, as Deputy 1 was out of sight of the camera when he provided the mattress to Daniels. According to an Incident Report written by Deputy 1, he “tossed” a mattress to where Daniels was standing, and cited safety concerns of approaching Daniels. According to Deputy 1’s Incident Report, Daniels called over the intercom requesting (Deputy 1’s) badge number and requested to be taken to be examined by medical staff. Daniels’ medical records confirmed he was seen by medical staff. SERFs were sent to Deputies 1 and an additional Deputy, requesting further information about this incident, and their confidential statements were considered as evidence in determining this finding. Considering policies and procedure (P&P) related to this incident, SDSD P&P Section 2.4, Unbecoming Conduct, stated, “Employees shall conduct themselves at all times, both on and off duty, in such a manner as to reflect most favorably on this Department. Unbecoming conduct shall include that which tends to bring this Department into disrepute or reflects discredit upon the employee as a member of this Department, or that which tends to impair the operation and efficiency of this Department or employee.” Additionally, SDSD P&P Section 2.48, Treatment of Persons in Custody, stated, “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.” It was clear that aggressively throwing a mattress towards someone would be a clear policy violation. However, in this case it is not clear how the mattress was given to Daniel’s, other than

it was not handed to him. It was also not clear if Daniels sustained an injury from the mattress. Ultimately, given the subjective definitions of "tossed" or "thrown", limited video evidence related to this incident, and information from the SERF responses and Daniels complaint, it is unclear whether Deputy 1 violated SDSD P&P through his actions. There was insufficient evidence to either prove or disprove the allegation.

3. Misconduct/Intimidation – Deputy 1 threatened to "kill" incarcerated person Daniels if he reported the incident.

   Board Finding: Not Sustained
   Rationale: Daniels stated, "Then he told me he'd kill me if I reported his actions…" Unfortunately, the barriers which prevent making a finding in allegation #1, other than not sustained, were also present with this allegation. Both Deputy 1 and an additional Deputy, in their SERF responses, provided confidential statements which were considered as evidence in determining this finding. There was insufficient evidence to either prove or disprove the allegation.

23-055/CUEVA

1. Use of Force Resulting in Great Bodily Injury – Deputies Dennard, Lewis, and Payton used force to subdue and arrest Edwin Mariano Cueva at the El Cajon Courthouse on 11-04-22.

   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 afternoon of 11-04-22, Deputy Lewis conducted a security check of the El Cajon Courthouse parking structure when he encountered Edwin Mariano Cueva sitting in his vehicle. Upon contacting Cueva, Deputy Lewis developed probable cause to detain Cueva. Deputy Lewis instructed Cueva to exit his vehicle. Cueva refused to comply with the deputy's commands and announced that he had a gun. Additional deputies were summoned to the scene, and Deputies Dennard and Payton responded. A use of force ensued, and Cueva was forcefully removed from his vehicle. Cueva was arrested on multiple illicit drug charges and weapons charges. Prior to his transport to jail, Cueva was transported to a hospital, where he was found to have sustained a wrist fracture according to the Arrest report. The deputies' use of force coincided with the actions dictated in their written reports. As of the time of this incident, not all court deputies were trained or authorized to use Body Worn Cameras (BWC) and were not provided individual Body Worn Cameras for use. As such, there were no BWC recordings of this use of force. Additionally, the San Diego Sheriff's Department did not impound or retain the courthouse surveillance video recordings of the parking lot were the use of force occurred. As such, no surveillance video recordings of the parking lot were made available to review during this investigation. Nonetheless, in review of evidence that was made available, which included numerous deputy reports and statements, the force used against Cueva was determined to be necessary, appropriate, effective, and reasonable given the circumstance and for deputies to gain compliance. During the incident, Cueva exhibited active and passive resistance towards the deputies. In response, the deputies executed physical force control techniques. The actions executed by the deputies were 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 it was lawful, justified, and proper.

2. Excessive Force - Deputies 1-3 injured Cueva's shoulder during his arrest.

   Board Finding: Unfounded
   Rationale: On 09-01-23, Edwin Mariano Cueva contacted CLERB and submitted a signed complaint related to this incident. In his written complaint to CLERB, Cueva alleged that he sustained a shoulder fracture in addition to his wrist fracture during his arrest. According to a SDSD report, it was noted that paramedics were summoned to the scene after Cueva had complaints of pain. Cueva was transported to a hospital where he was evaluated and received treatment. Medical records were obtained from both the hospital and

from the jail. Those records were reviewed; however, that information cannot be disclosed due to the Health Insurance Portability and Accountability Act (HIPPA) which protects the individual's sensitive health information. Additionally, Body Worn Camera recordings of the arrest were reviewed. It was noted that at the time of the incident, Cueva likened his shoulder pain from a childhood injury. The evidence showed that the allegation that Deputies 1-3 injured Cueva's shoulder during his arrest did not occur.

23-065/ROBERTSON

1. Misconduct/Procedure – Unidentified Probation Department staff decreased Alicia Robertson's visits with the aggrieved.

   Board Finding: Action Justified
   Rationale: Alicia Robertson contacted CLERB and reported that visits with her grandson, Devin C. (aggrieved), have been reduced from six to four days a week at East Mesa Juvenile Detention Facility (EMJDF). Probation Department Institutional Services Policies (P&P), Section 6.5, Visiting Program, stated, "Title 15, Section 1374, sets forth the guidelines for incorporating a visiting schedule into Facility programs. Compliance with these guidelines mandate that each detention facility shall allow youth a weekly visit by parents, guardians or persons standing in-loco-parentis. Opportunity for visitation shall be a minimum of two hours per week. The visiting program will consist of visiting hours and days which are determined by each facility." Regarding visitation at EMJDF, the Probation Department provided information that on 05-10-23, in-person visits were reduced to a maximum of four visits per week. The Probation Department provided they made this change due to the high youth count in the facility and being unable to accommodate both a high number of virtual and in-person visits. In-person visits remained one hour in length. Additionally, for in-person visits, appointments must be made prior to the actual visitation time, and can include up to two visitors. The evidence showed that Robertson was correct, the Probation Department did reduce visitation to a maximum of four visits per week, but there was no misconduct. Title 15 Minimum Standards for Juvenile Facilities required youth be allowed a minimum of two hours of visiting per week. The Probation Department remains in compliance with State guidelines regarding visitation. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

2. Misconduct/Procedure – Unidentified Probation Department staff cancelled holiday visits.

   Board Finding: Action Justified
   Rationale: Complainant Robertson reported that visits on Mother's Day & Father's Day were cancelled. The Probation Department confirmed that visitation was cancelled on both alleged days. Documentation provided showed that visitation was cancelled due to significant staffing shortages at EMJDF. Referring to P&P, Section 6.5, Visiting Program, and Title 15 guidelines, "The visiting program will consist of visiting hours and days which are determined by each facility." Ultimately, canceling visitation on the referenced dates was not a violation of P&P or State guidelines. Further, the Probation Department has the authority to modify its visitation program if it meets the minimum requirements set forth in Title 15. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

3. Misconduct/Procedure – Unidentified Probation Department staff denied Robertson's scheduled visit with the aggrieved on 06-06-23.

   Board Finding: Unfounded
   Rationale: Robertson reported that on 06-06-23, she called the EMJDF to confirm her visit with her grandson, which was scheduled for later that day. When Robertson arrived for the visit she was told she did not have a visit and was turned away. Documents received from Probation included both contact logs and the visitation appointment calendar. Ultimately, the records indicated that no call was made on 06-06-23, and further, no appointment was scheduled to visit the aggrieved on that date. The preponderance of evidence showed that this allegation was unfounded. The evidence shows that the alleged act or conduct did not occur.

23-084/SWIM

1. Misconduct/Procedure – Unidentified deputies failed to address David Swim's reports of neighborhood violence.

   Board Finding: Not Sustained
   Rationale: On 08-30-23, Complainant Swim reported, "This is a complaint of a long term failure by the SD Sheriff's office and personnel to respond, inquire, take information seriously, patrol our neighborhood after 3 shootings {one which had bullets going straight through the front walls of one apt in the front which if Lorraine (tenant) had been sitting on her couch, would have killed her), the arrest of a criminal with guns across the street, 2 dead bodies - one across the street, one 1 block away, and the murder of a 17 year girl in the complex right behind us! Also, last year, one of the drug addicts living across the street from our complex, stalked me up and down the street threatening to "mess you up - kill you" as witnessed by a property owner 2 apt complex south of us. Also, unending racial bigotry, slurs, racist profanity, etc continually spews out of these sewer rats pretending to be humans!" Swim provided no supporting documentation pertaining to these events. Sheriff's records documented a call for service at 3631 S. Bonita Street, Spring Valley on 07-13-23, and four different calls for service to 3644 S. Bonita Street, Spring Valley on 04-12-23, and 04-23-23 at 9:56am and 5:15pm. Given the lack of information and evidence provided by the complainant and SDSD records, there was insufficient evidence to either prove or disprove the allegation.

2. Misconduct/Procedure – Unidentified deputies failed to provide Swim with a police report and/or "hid" identifying information about a suspect.

   Board Finding: Not Sustained
   Rationale: On 08-30-23, Complainant Swim reported, "After calling the Sheriff, and having them come out for the incident, my repeated efforts to gain a copy of the police report, as well as the name of the criminal drug dealer who threatened me so I could file for a restraining order - THE SHERIFF HAS BEEN COMPLETELY HIDING THE INFORMATION, AND REFUSES TO PROVIDE THE NAME! NO COOPERATION AT ALL!" Swim provided no supporting documentation pertaining to these events. SDSD reported they had no calls for service involving the complainant pertaining to this event. Given the lack of information and evidence provided by the complainant and SDSD records, there was insufficient evidence to either prove or disprove the allegation.

3. Misconduct/Procedure – SDSD's leadership has failed to take promised action.

   Board Finding: Not Sustained
   Rationale: On 08-30-23, Complainant Swim reported, "Another contributing factor to lawlessness that contributes to the SD Sheriff's office ignoring the citizens living in this hell hole, is the fact we don't have a County Supervisor. If the current leading candidate wins for the seat, I EXPECT NOTHING TO HAPPEN, ACTUALLY WORSE! She is a BLM and criminal supporting councilwoman with a terrible record for protecting citizens. What is further concerning is the response(COMPLETE LACK OF) coming from the SD Sheriff's office, their leaders, and the complete lack of action promised by the new Captain. When I was invited to a "Coffee with the Community" meeting on Tuesday May 16th, IT WAS A COMPLETE JOKE OF A PR EVENT! There was NO ONE there from the Sheriff ready & willing to really listen to citizens. She acted like this was a "tea and crumpets" get together so we could compare fantasies and lies about how "serious we are" to protect the community! Complaints from others about the phony, non-existent (except the sign, but always closed) Community Relations office here in Casa de Oro, were treated with light hearted - "well, we'll see what we can do". ALL WHILE CITIZENS ARE TREATED WORSE THAN CRIMINALS!" Given the lack of information and evidence provided by the complainant, there was insufficient evidence to either prove or disprove the allegation.

4. Misconduct/Procedure – Crime Prevention Specialist Ortiz failed to return phone calls or assist the community.

Board Finding: Summary Dismissal
Rationale: On 08-30-23, Complainant Swim reported, “I was even given contact for another FRAUDULENT person named JOSE. Supposedly he is a "CRIME PREVENTION SPECIALIST". WHAT A JOKE - FRAUD - PHONY & LIAR! He doesn't return phone calls or assist in any way! Is he in a paid position? Who working with the SD Sheriff actually is willing to take ANY RESPONSIBILITY for their failures to protect citizens in our neighborhood?“. Crime Prevention Specialists are non-sworn personnel and do not fall under CLERB’s jurisdiction. Pursuant to CLERB Rules and Regulations, Section 4.1 Complaints: Authority, stipulates that CLERB only has authority to investigate complaints filed against peace/custodial officers employed by the San Diego Sheriff’s Department. The Review Board lacks jurisdiction.

5. Misconduct/Procedure – Unidentified SDSD staff were “flippant, smirking” and failed to act.

   Board Finding: Not Sustained
   Rationale: On 08-30-23, Complainant Swim reported, “In conclusion-while knowing at least 5 persons in the SD Police and SD Sheriff positions here in San Diego, I am filled with disgust, contempt and frustration that comes from the flippant, smirking faces and actions from those in the SD Sheriff I have tried to work with!“ Swim provided no identification or supporting documentation pertaining to these events. Given the lack of information and evidence provided by the complainant, there was insufficient evidence to either prove or disprove the allegation.

23-103/KELLY

1. Illegal Search & Seizure – San Diego Harbor Patrol towed Sean Kelly’s vehicle.

   Board Finding: Summary Dismissal
   Rationale: Sean Kelly stated, “Upon my return, my vehicle was missing and harbor police advised me they have a report it had been towed by western towing, authorized by San Diego airport rental car center facilities manager.” 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. The actions of San Diego Harbor Police and employees with the San Diego Airport Rental Car management do not fall under CLERB jurisdiction. 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/Procedure – San Diego Airport Car Rental management “ignored” Kelly’s request for reimbursement.

   Board Finding: Summary Dismissal
   Rationale: Kelly stated, “I spoke to the car rental manager on the phone and emailed receipts, requesting reimbursement for the unlawful tow per CA VEH Code 22511.5 and was ignored.” See Rationale #1.

3. Misconduct/Procedure – San Diego Airport Car Rental management “lacked” knowledge of ADA law.

   Board Finding: Summary Dismissal
   Rationale: Kelly stated, “I later emailed the supervisor who responded, in writing, his lack of knowledge of the law, ignored the code i included which is egregious. It is obvious there is a serious lack of ADA and disabled parking laws training at the San Diego airport.” See Rationale #1.

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.