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CITIZENS' LAW ENFORCEMENT REVIEW BOARD

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REGULAR MEETING AGENDA
Tuesday, January 30, 2024, 5:30 p.m.
County Administration Center
1600 Pacific Highway, Room 302, San Diego, 92101

(Free parking is available in the underground parking garage, on the south side of Ash Street, in the public parking spaces.)

-AND-

Zoom Platform

https://us06web.zoom.us/j/86564632749?pwd=7wyZbStGwRCYjhwaUWwWLXg4E1ps7q.1

Phone: +1 669 444 9171

Webinar ID: 865 6463 2749

Passcode: 146959

Pursuant to Government Code Section 54954.2 the Citizens' Law Enforcement Review Board will conduct a meeting at the above time and place for the purpose of transacting or discussing business as identified on this agenda. Complainants, subject officers, representatives, or any member of the public wishing to address the Board should submit a "Request to Speak" form prior to the commencement of the meeting.

DISABLED ACCESS TO MEETING

A request for a disability-related modification or accommodation, including auxiliary aids or services, may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting. Any such request must be made to CLERB at (619) 238-6776 at least 24 hours before the meeting.

WRITINGS DISTRIBUTED TO THE BOARD

Pursuant to Government Code Section 54957.5, written materials distributed to CLERB in connection with this agenda less than 72 hours before the meeting will be available to the public at the CLERB office located at 555 W Beech Street, Ste. 220, San Diego, CA.

1. **ROLL CALL (One minute)**

2. **PUBLIC COMMENTS (45 minutes)**

   This is an opportunity for members of the public to address the Board on any subject matter that is within the Board's jurisdiction but not an item on today's open session agenda. **Each speaker shall complete and submit a "Request to Speak" form.** Each speaker will be limited to three minutes. This meeting will also be held remotely via the Zoom Platform. Click the link in the agenda header above to access the meeting. Contact CLERB at clerb@sdcounty.ca.gov or 619-238-6776 if you have questions.

3. **CLOSED SESSION: TIME CERTAIN – 6:15 pm**

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).

CASES FOR SUMMARY HEARING (24)

NOTICE: THE CITIZENS LAW ENFORCEMENT REVIEW BOARD (CLERB) MAY TAKE ANY ACTION WITH RESPECT TO THE ITEMS INCLUDED ON THIS AGENDA. RECOMMENDATIONS MADE BY STAFF DO NOT LIMIT ACTIONS THAT THE CLERB MAY TAKE. MEMBERS OF THE PUBLIC SHOULD NOT RELY UPON THE RECOMMENDATIONS IN THE AGENDA AS DETERMINATIVE OF THE ACTION THE CLERB MAY TAKE ON A PARTICULAR MATTER.

DEATH INVESTIGATIONS (5)

21-125/BORUNDA (Inv. Wigfall)

1. Death Investigation/Drug Related - Jerry Borunda, while an inmate at San Diego Central Jail, was found unresponsive in his cell on 12-01-21.

   Recommended Finding: Not Sustained
   Rationale: Jerry Borunda was a 63-year-old Hispanic male that resided in the San Diego area. On 11-30-21, Borunda was arrested by the San Diego Police Department (SDPD) with attempted murder charges. SDPD transported Borunda to a hospital where he reported that he used fentanyl. Borunda was cleared by medical staff then booked into the San Diego Central Jail (SDCJ). According to SDSD documentation, Borunda was placed in the Inmate Safety Program (ISP) during the booking process for homicidal ideations and classified as Level 5 (due to his charges). SDSD documentation showed at approximately 08:35am, a deputy and medical staff approached Borunda's cell and offered him his medication. Jail surveillance video showed that Borunda got out of his bunk, walked towards the cell door, and took his medication. Jail medical records showed Borunda was given an antihistamine and other medication used to treat nausea, vomiting and diarrhea per opioid withdrawal protocol. A deputy and medical staff walked through the module at approximately 09:22am and reported Borunda "was not in distress and his voice appeared normal." Surveillance video showed that at approximately 09:23am, Borunda sat up on his bunk and ate some food. The last security check before he was found unresponsive was at 09:28am. At approximately 9:37am, video showed Borunda lying in the bunk where he appeared to have a medical episode. Deputy 1 found Borunda unresponsive and called for medical assistance. (Please note this last security check went over the 15-minute time mandated by policy and is addressed in allegations 3 & 4.) Deputies and medical staff administered lifesaving measures until the fire department arrived and transported Borunda to a hospital where he was placed on life support until he died on 12-19-21. The San Diego Medical Examiner's Office (SDMEO) conducted an external examination and determined the cause of death to be anoxic encephalopathy due to resuscitated cardiorespiratory arrest due to acute fentanyl toxicity with contributing factor of blunt force torso trauma and the manner of death was an accident. According to a urine sample taken at the hospital about four hours after Borunda was found unresponsive, fentanyl and its metabolite, norfentanyl, was detected. No illicit substances were found in Borunda's cell and there was no evidence that Brunda attempted to use the intercom to call for assistance. The Critical Incident Review Board (CIRB) conducts a review of all in-custody deaths. The CIRB release for the death of Borunda stated, "The CIRB conducted a review of this incident on May 11, 2022, with no action items or policy recommendations at that time." The release also stated, "The Medical Examiner determined the cause of death to be "anoxic encephalopathy" due to "resuscitated cardiorespiratory arrest" and "acute fentanyl toxicity" with "blunt force torso trauma" contributing, and the manner of death to be "accident." There were no policy violations found with deputies' response to Borunda's medical emergency.

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

   Recommended Finding: Not Sustained

Rationale: Borunda died following his incarceration at the San Diego Central Jail (SDCJ) due in part to acute fentanyl toxicity. See Allegation #1. Borunda was found unresponsive approximately twelve hours after being booked into custody. Borunda reported he used fentanyl two days prior to his arrest. A SDMEO Forensic Toxicology Lab Manager responded to an Employee Response Form (ERF). According to the response the only information that could be derived from the quantitative amount found in Borunda's urine sample is that "at some point" he consumed fentanyl. Given the lack of information surrounding the fentanyl usage, it was unknown if Borunda obtained and/or ingested fentanyl inside the jail. To summarize, there is not enough information to determine if SDSD failed to keep illicit drugs outside of the jail for the matter in question. Unfortunately, there have been several fentanyl related deaths in the San Diego County Jails, despite the numerous measures that SDSD has implemented to deter drugs from entering its detention facilities, 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 VDF, SDCJ intake facilities and GBDF and 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. There were new policies adopted by the SDSD such as M.47 Suspected Opioid Overdose, effective 12-01-22 and M.48 Naloxone Issuance and Storage, effective 02-07-23. Both policies aim to ensure each detention facility has access to Naloxone and provide appropriate procedure in the event of a suspected opioid overdose. Also, 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 12-28-22, SDSD advised it would not implement the searching or scanning recommendations. On 01-18-23, CLERB re-submitted the policy recommendations and on 12-07-23, SDSD responded that "there has been no change in the Sheriff's Department's policy on utilizing body scan technology for all individuals, including employees, entering detention facilities. We are actively exploring processes, technology, practical application, and operational efficiencies related to locating potential contraband that could be brought in via staff, contractors, and visitors to our facilities. We are sensitive to protecting the security of our facilities and our staff by not revealing publicly too much of our methods regarding all screening processes. We do have practices in place that actively work to identify and address any employee and/or staff misconduct in this area." In closing, the investigation failed to determine if the fentanyl that contributed to Borunda's death was obtained inside the jail or if the fentanyl detected was consumed before his arrest. There was insufficient evidence to either prove or disprove the allegation.

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

Recommended Finding: Sustained
Rationale: According to Detention Services Bureau (DSB) Policy and Procedure (P&P) Section J.1 Safety Cells: Definition and Use, every incarcerated person in a safety cell, **"shall be directly observed by sworn staff at random intervals not to exceed 15 minutes between checks."** (emphasis added). Jail surveillance video showed the last safety and security check conducted by Deputy 1 was done at 09:45 am and 19 seconds, which was 16 minutes and 33 seconds after the last check by a deputy at 9:28 am and 46 seconds. Please note, this is **NOT** a title 15 violation, as Title 15 states in Section § 1055. Use of Safety Cell that, "Direct visual observation shall be conducted at least twice every thirty minutes." As indicated above, SDSD's policies mandate the direct visual observation of incarcerated persons housed in a safety cell with no more than a 15-minute lapse between the direct visual observations. SDSD's current practice, however, is to start safety checks within the mandated time-period but not necessarily to directly visualize each incarcerated person within that time-period, thus resulting in innumerable instances where incarcerated persons are not directly visually observed within statutorily mandated time-periods. SDSD considers the resulting safety checks to be completed within statute and policy. For example, if a safety check of a module is started within 13 minutes of the last safety check start time, SDSD considers the safety checks occurring during that check as within statute and policy, even if the actual time between direct visualization of an incarcerated person is just a few minutes over 15 minutes. In CLERB Case 21-069/Rodriguez, CLERB recommended SDSD take all necessary measures to change its current practice to conform with statute and its own existing policy by mandating that every incarcerated person be directly observed by sworn staff at

random intervals not to exceed 60 minutes (30 minutes for Medical Observation Beds and in Psychiatric Stabilization Units and 15 minutes for safety cells), as opposed to simply ensuring the safety checks start within the mandated time-period. The SDSD responded but failed to adopt CLERB's recommendations. In closing, Deputy 1 responded to a Sheriff Employee Response Form (SERF) and provided a confidential statement that was considered in the outcome of these recommended findings. The evidence supports the allegation, and the act or conduct was not justified.

4. Misconduct/Procedure – Deputy 1 failed to conduct timely safety/security checks.

   Recommended finding: Not Sustained
   Rationale: On 12-01-23, Deputy 1 found Borunda unresponsive in his cell while he performed his safety and security check. Deputy 1 began his check at 9:42am but did not get direct visualization of Borunda until 9:45am, which elapsed the 15-minute mandate in accordance with policy by 1 minute and 33 seconds. *Please see Allegation #3* Deputy 1 responded to a Sheriff Employee Response Form (SERF) and provided a confidential statement that was considered in the outcome of these recommended findings. Given this is their "common practice", CLERB will not recommend a sustained finding against Deputy 1, as he followed the standard practice but, instead, make another policy recommendation to eliminate this systemic practice, which in turn may help save a life.

   POLICY RECOMMENDATION:

   1. It is recommended that the Sheriff's Department update its policy, Section J.1 Safety Cells: Definition and Use to read as follows: Every incarcerated person in a safety cell shall be directly observed by sworn staff at random intervals not to exceed 15 minutes between each **direct visualization of the incarcerated person. The start time of each security check does not count towards the actual direct visualization of the incarcerated person**. Such observations shall be documented on the J-19A form.

21-130/McCOY (Inv. Aldridge)

1. Death Investigation/In-Custody Homicide – Incarcerated Person (IP) Dominque James McCoy died while in the custody of the Sheriff's Department after his cellmate assaulted him.

   Recommended Finding: Sustained
   Rationale: Incarcerated Person (IP) Dominque James McCoy was incarcerated at the San Diego Central Jail after his 12-22-21 arrest. On 12-29-21, McCoy attended court. While McCoy was away at court, another IP was assigned to the same jail cell as he. According to McCoy's court documents of his court proceedings, the court ordered for him to be released from custody that day. Upon his return to the jail, he was returned to his cell while detentions processing staff managed his release from custody. During a safety/security check, detention deputies observed McCoy's cellmate attacking him. Deputies intervened and rendered medical aid to McCoy. McCoy was transported, via ambulance, to a local hospital where he succumbed to his injuries and was pronounced deceased. According to Medical Examiner reports, McCoy's cause of death was blunt force injuries of the head, and the manner of death was homicide. McCoy was noted to have sustained facial and scalp abrasions, contusions and lacerations, hemorrhages to his scalp, skull fractures, brain hemorrhage, and neck abrasions. The evidence supported that McCoy was properly classified upon his incarceration into the SDSD jail system after his arrest. Upon being found down and unresponsive in his cell, sworn personnel responded and immediately initiated life-saving measures. An examination of the specific facts and circumstances surrounding the assault were reviewed. Based on IP Medina's documented propensity towards violence, the Department failed to implement reasonable measures to prevent him from him doing harm to others, shortcomings that contributed to IP McCoy's death. The lack of protection to IP McCoy cannot be attributed on one individual, but as a department, the SDSD failed to provide a safe environment for McCoy. According to SDSD Detention Services Policies and Procedures (DSB P&P) Section I.63 titled Facility Security-Housing Units, "a safe atmosphere for inmates [incarcerated persons] will be maintained." (emphasis added) It was incumbent by the entire SDSD to take responsibility by providing a safe environment for all persons under their care. The Department was responsible for arranging a safe environment for those in its custody and to identify and facilitate proactive ways in safeguarding

individuals in housing units with mixed classification/security levels. The evidence showed a systematic failure of a combination of issues, which ultimately accounted for IP McCoy being placed in an unsafe environment. Despite medical protocols and pandemic-related challenges, the SDSD had a duty to provide a safe environment for all incarcerated persons. The SDSD was responsible for the safety, security, and well-being of all individuals under their care, even during pandemic protocols. Inadequate housing availability led to the SDSD inability and failure in providing McCoy with a safe environment. The SDSD did not implement reasonable measures in housing a low-level and high-level incarcerated person together, which subsequently led to McCoy's death. The evidence supported the allegation and the act was not justified.

2. Misconduct/Procedure – Deputies 1 and 2 classified and housed IP Medina with IP McCoy.

   Recommended Finding: Action Justified
   Rationale: Deputy 2 classified Medina as a high security/classification IP. Deputy 1 housed IP Medina in a housing unit with mixed security/classification levels. Per a Department Information Source, there are exceptions when incarcerated persons are housed in a housing unit with mixed classification levels. According to California Title 15 Minimum Standards for Local Detention Facilities Article 5 – Classification and Segregation § 1050 titled “Classification Plan” facility shall develop and implement a written classification plan designed to properly assign inmates to housing units according to the categories of sex, age, criminal sophistication, seriousness of crime charged, physical or mental health needs, assaultive/non-assaultive behavior, risk of being sexually abused or sexually harassed, and other criteria which will provide for the safety of the inmates and staff. Housing unit assignment shall be accomplished to the extent possible within the limits of the available number of distinct housing units or cells in a facility. According to SDSD DSB P&P Section R.1 titled ‘Incarcerated Person Classification,’ is to screen, assess and house incarcerated persons in a manner that will protect the safety of the community, staff and other inmates. This investigation found that during the Covid-19 situation, protocols were enacted to complete quarantine protocols implemented by the SDSD Medical Services Division, based on a quarantine/isolation separation plan. COVID-19 housing units were considered medical quarantine housing units to fit the needs of the jail during that time. These COVID protocols that were implemented allowed for high level and low level incarcerated persons to be housed. The evidence showed that the alleged act of classifying and housing IP Medina with IP McCoy did occur, and given the situation, it was lawful, justified and proper.

3. Misconduct/Procedure – The San Diego Sheriff’s Department failed to separate IPs according to risk levels.

   Recommended Finding: Not Sustained
   Rationale: This investigation reviewed the SDSD’s investigations and the circumstances surrounding McCoy’s death to determine the cause and whether any wrongdoing occurred. The evidence indicated that the SDSD failed to fulfill its duty to maintain the welfare of incarcerated persons while they were in their custody. Due to the rapidly evolving COVID-19 situation, the Department implemented operational changes within its facilities. These changes included isolating newly incarcerated persons together, irrespective of their classification or security levels. Housing units were modified to serve as quarantine/isolation modules. In these designated "medical modules," both low-level and high-level individuals were mixed and housed together. California Title 15 Minimum Standards for Local Detention Facilities, Classification and Segregation §1050 allows for housing assignment to be based on a facilities availability, to the extent possible within the jail’s limits of the available number of housing units or cells in a facility. Despite the COVID-19 protocols in place, the investigation concluded that the Department had a duty to provide a protected environment for all individuals under their care. This duty extended to ensuring the safety, security, and well-being of incarcerated persons. The Department was held responsible for managing incarcerated persons safely and securely, even during the implementation of COVID-19 protocols. CLERB emphasized that the Department had the responsibility to develop a plan that did not jeopardize the welfare of those under their care. Though the act of failing to separate IPs according to risk levels was not a violation of California law, CLERB’s investigation suggest the need for systemic changes and improvements to prevent similar incidents in the future. There was insufficient evidence to either prove or disprove the allegation.

POLICY RECOMMENDATIONS:

1. CLERB recommends that the SDSD enact a procedure that allows for the safe placement of all IPs who are released from custody, regardless of the circumstances of their release. In addition to a policy that governs all release, it is recommended that IPs shall not be allowed to return to housing if released from or while at court.

2. CLERB recommends that Jail Population Management Unit deputies have the ability to review and consider juvenile records and sealed records in cases they deem necessary.

22-010/GIL (EO Parker)

1. Death Investigation/In-Custody Drug-Related – On 02-14-22, Gilbert Gil, an incarcerated person at Vista Detention Facility (VDF), was found unresponsive in his cell by deputies. Despite aggressive resuscitative efforts, he was pronounced dead while at the jail. Methamphetamine toxicity contributed to his death and the manner of death was accident.

   Recommended Finding: Not Sustained
   Rationale: On 02-13-22, Gilbert Gil was arrested by Escondido Police Department (EPD) officers for being under the influence of a controlled substance after a family member summoned EPD and advised that Gil was "very confused and belligerent" and was "hitting walls and not acting himself." The family member further stated that Gil had a history of methamphetamine usage, but he did not know if he had used that day. Another family member also confirmed that Gil was a user of methamphetamine. EPD officers transported Gil to Palomar Medical Center where he was medically cleared for booking and issued educational material for methamphetamine use disorder. EPD transported Gil to the Vista Detention Facility (VDF) where he was booked on 02-14-22 at approximately 3:00 a.m. After security checks were properly conducted within policy over the next 15 or so hours, he was found unresponsive in his single occupancy cell during a security check. Deputies started CPR and administered Narcan. After about 35 minutes of continuous CPR, two doses of Narcan, and aggressive resuscitative efforts undertaken by deputies, medical service providers, and Vista Fire Department personnel, Gil was pronounced dead while at VDF via radio by a doctor from Tri-City Medical Center at 6:40 p.m. On 02-15-22, the San Diego Medical Examiner's Office conducted an autopsy. The cause of death was hypertensive cardiovascular disease with contributing causes of diabetes mellitus, methamphetamine toxicity, dehydration, hepatic steatosis and fibrosis, and pulmonary emphysema. Due to the methamphetamine toxicity contributing to the death, the manner of death was accident. The family pursued a second autopsy but the final report was allegedly unable to be completed due to lack of access to initial toxicology specimens. According to SDSD medical records, upon booking into VDF, Gil's glucose level was 253 and he was administered five units of regular insulin per the established treatment plan. There was a notation that Gil was a user of "meth," and just prior to being booked he had been cleared for booking by a PMC physician. Based upon his medical assessment, he was medically cleared and deemed "fit to book." While all evidence indicated that Gil was medically screened and assessed and treated by medical staff upon booking, there is no indication that any other medical care was provided until he was found unresponsive. SDSD has implemented and taken measures to deter drugs from entering their detention facilities. There is no indication that Gil obtained or consumed methamphetamine during his incarceration. Per SDSD P&P 4.23 titled Department Committees and Review Boards. The Critical Incident Review Board (CIRB) conducts a review of all in-custody deaths. According to the SDSD website, the releases "are synopses of reviewed incidents and any resultant actions or policy changes intended to improve our operations. In some instances, the information contained in these releases may be fragmentary or incomplete and are subject to update as information is verified or confirmed. The release of information related to a matter involving potential criminal prosecution or civil litigation may delay or limit the amount of information released until the conclusion of the case." The CIRB release for the death of Gil stated, "The Medical Examiner's Office determined the cause of death to be hypertensive cardiovascular disease with diabetes mellitus, methamphetamine toxicity, dehydration, hepatic steatosis and fibrosis, and pulmonary emphysema contributing, and the manner of death to be accident. The CIRB conducted a preliminary review of this incident on April 13, 2022. There were no action items identified as a result of that review." There is insufficient evidence to indicate whether additional medical care provided during the 15 or so hours Gil was in VDF would have prevented this death.

2. Misconduct/Medical (I/O) – Unidentified medical staff failed "to medically monitor" Gil "for 15 hours."

Recommended Finding: Summary Dismissal
Rationale: See Rationale #1. As CLERB does not have jurisdiction to investigate allegations against medical service providers working in SDSD detention facilities, this allegation must be summarily dismissed.

3. Excessive Force – Unknown deputies used force on Gil on either 02-12-22 or 02-14-22.

Recommended Finding: Unfounded
Rationale: According to SDSD records, there was no indication that force was ever used on Gil during his incarceration periods on 02-12-22 or 02-14-22. The evidence shows that the alleged act or conduct did not occur.

22-031/RUPARD (Inv. Chiesa)

1. Death Investigation/In Custody Homicide - Lonnie Rupard, while in San Diego Sheriff's Department custody at San Diego Central Jail, died in a setting of neglected schizophrenia.

Recommended Finding: Sustained
Rationale: SDSD records showed Rupard was housed in Housing Unit 7D, Cell 17, bed B on 12-22-21. This is the same cell in which he was eventually discovered unresponsive. From housing placement to date of death, Rupard was housed in cell 17 for a total of 85 days. Of those 85 days, SDSD records showed Rupard had approximately 19 documented dayroom refusals, six meal refusals, and one shower refusal. This does not account for the meals that were accepted by Rupard but not eaten, as well as shower or meal refusals that were not logged. Shower refusals are not required to be logged. From the time Rupard was taken into custody until his death, he suffered a 60lb weight loss or 36% of total body weight. The evidence suggested Rupard's cell was known to be covered in trash and feces. SDSD DSB P&P L.2 titled Sanitation and Hygiene Inspections, states facility hygiene inspections will be outlined in facility green sheets. The facility green sheet for San Diego Central Jail (SDCJ) states hygiene inspections for module 7D shall be conducted on Saturdays. The green sheet also states, "SDCJ health staff will be notified of any incarcerated persons exhibiting extremely poor hygiene, self-neglect or the inability to take care for oneself. A health exam should be conducted by health staff to check on the individual's wellbeing. An ISR will be written documenting who conducted the evaluation, their ARJIS and the outcome." CLERB was unable to determine if hygiene inspections were conducted weekly as required by facility green sheets (*See Rationale 2 and 3*). This is unfortunate as this critical function presents the opportunity for deputies to notify health staff of concerns for the wellbeing of incarcerated persons. During Rupard's medical intake screening and subsequent interactions with SDSD medical personnel, to include psychiatric staff, Rupard's care was postponed due to time constraints or for refusal to participate by Rupard. Records document that care was made available to Rupard in the form of meals, and continuous in-cell water supply, however due to his psychiatric illness Rupard did not always accept. Rupard continuously refused prescription medications which were ultimately canceled due to his repeated refusals. While a mental competency evaluation ultimately determined Rupard was unfit to stand trial, the determination was made too late to give Rupard the care he needed. The ineffective delivery of care cannot be pinned on one individual, but as a department the SDSD failed to intervene and arrange for Rupard to be transported to a medical facility for the purpose of receiving an obviously needed higher level of care. On 03-19-22, an autopsy was conducted on Rupard at the San Diego County Medical Examiner's Officer (SDMEO). The cause of death was pneumonia, malnutrition, and dehydration in the setting of neglected schizophrenia, with COVID-19, pulmonary emphysema, and duodenal ulcer as contributory. SDMEO opined that while elements of self-neglect were present, ultimately Rupard was dependent upon others for his care; therefore, the manner of death was homicide. It is incumbent by the entire SDSD to take responsibility to care for those in their custody and identify and facilitate a higher level of care when needed. While CLERB does not currently have jurisdiction of medical personnel, the evidence showed an egregious neglect of care and ultimate failure of the system. Per SDSD P&P 4.23 titled Department Committees and Review Boards. The Critical Incident Review Board (CIRB) conducts a review of all in-custody deaths. According to the SDSD website, the releases "are synopses of reviewed incidents and any resultant actions or policy changes intended to improve our operations. In some instances, the information contained in these releases may be fragmentary or incomplete and are subject to update as information is verified or confirmed. The release of information related to a matter involving potential criminal prosecution or civil litigation may delay or limit the amount of information released until the conclusion of the

case." The CIRB release for the death of Lonnie Rupard stated, "The CIRB conducted a preliminary review of this incident on April 20, 2022, and listed the following as action items: Item #1 – The circumstances of the incident were referred to the Sheriff's Internal Affairs Unit for review." The release also stated the cause and manner of death "are still pending the completion of the Medical Examiner's final report". In CLERB #22-053/Ornelas, CLERB made three recommendations to CIRB reviews which included: 1. Post Critical Incident Review Board (CIRB) Reviews on the SDSD website within 10 days of the review. 2. Update CIRB Reviews on the SDSD website within five days of obtaining applicable information. And 3. Include all contributing causes of death in the CIRB Review posted on the SDSD website. The policy response is still pending from the department. The evidence supports the allegation and the act or conduct was not justified. The evidence supports the allegation and the act or conduct was not justified.

2. Misconduct/Procedure - SDSD did not retain hygiene inspection results.

   Recommended Finding: Sustained
   Rationale: Through the course of investigation, CLERB discovered hygiene inspection results were not retained. According to an email from Division of Inspectional Services, there were no hygiene inspection sheets retained from 12-22-21 to 03-17-22. The San Diego County Retention Policy Schedule Report for Owning Department: SH states dormitory health and hygiene inspection results have a retention timeframe of two years. According to Division of Inspectional Services, "the sheets are generally the only place where results are noted." SDSD DSB P&P L.2 titled Sanitation and Hygiene Inspections, states facility hygiene inspections will be outlined in facility green sheets. The policy also states that the hard copies of completed weekly inspections will be kept on file for a period of six months. The policy states each facility will have a weekly hygiene inspection conducted by staff members. SDSD DSB policy contradicts San Diego County Retention Policy schedule *(See Policy Recommendation).* The evidence supports the allegation and the act or conduct was not justified.

3. Misconduct/Procedure- SDSD did not perform weekly hygiene inspections.

   Recommended Finding: Not Sustained
   Rationale: Through the course of investigation, CLERB discovered hygiene inspection for Rupard's module may not have occurred. SDSD DSB P&P L.2 titled Sanitation and Hygiene Inspections, states facility hygiene inspections will be outlined in facility green sheets. The facility green sheet for SDCJ states hygiene inspections for module 7D shall be conducted on Saturdays. The green sheet also states, "SDCJ health staff will be notified of any incarcerated persons exhibiting extremely poor hygiene, self-neglect or the inability to take care for oneself. A health exam should be conducted by health staff to check on the individual's wellbeing. An ISR will be written documenting who conducted the evaluation, their ARJIS and the outcome." SDSD records showed hygiene inspections were not conducted weekly, and the last documented weekly hygiene inspection for Rupard's module occurred 03-05-22. The previously documented hygiene inspection was 02-16-22. According to the facility green sheet, "cancellation of hygiene inspections shall be at the discretion of the watch commander. An entry shall be made in the watch commander's log and in JIMS articulating the affected area and reason for the cancellation." SDSD watch commander's log on 02-19-22 indicated a use of force during the hygiene inspections in module 5 but did not notate the cancellation of the remaining modules. Furthermore, the area activities report on 02-19-22 showed Area 7 Module E inspections were completed, but not Area 7 Module D (Rupard's module). SDSD watch commander's log on 02-26-22 and 03-12-22 did not notate any cancellation of hygiene inspections. On 02-26-22, there was an impact log notation that dayroom was delayed due to cell inspections but no documented cell inspections for Rupard's module. On 03-12-22, the area activities summary report showed inspections were completed in Area 7, Module A, B, and C (not D). According to an email from Division of Inspectional Services, there were no hygiene inspection sheets retained from 12-22-21 to 03-17-22. *See Rationale 2.* Due to the lack of evidence, CLERB was unable to determine if hygiene inspections for Rupard's module occurred and/or if inspections occurred but were not logged. There was insufficient evidence to either prove or disprove the allegation.

   POLICY RECOMMENDATION:

1. It is recommended the San Diego Sheriff's Department (SDSD) update L.2 titled Sanitation and Hygiene Inspections to retain hard copies of weekly inspections for a period of two years as required by County of San Diego Retention Policy Schedule.

22-080/GRANILLO (Inv. Chiesa)

1. Death Investigation/In-Custody Medical – Vianna Marissa Granillo, while an inmate at Las Colinas Detention and Reentry Facility, was found unresponsive in her cell on 07-12-22.

   Recommended Finding: Sustained
   Rationale: The evidence indicated Granillo should have never been booked into SDSD custody (*See Rationale 2)*. SDSD records indicated Granillo was classified in accordance with policy based on her booking charge. SDSD records showed at approximately 2:04AM Granillo was witnessed to be unresponsive with her back over the toilet and her head touching the floor. Deputies arrived and assisted in removing Granillo from the cell to evaluate Granillo. SDSD DSB P&P M.6 entitled "Life Threatening Emergencies: Code Blue" states any life-threatening emergency shall trigger a 9-1-1 request for a paramedic emergency response team. Additionally, sworn and health staff shall initiate emergency response and basic lifesaving measures until relieved by a paramedic emergency response team. Furthermore, SDSD DSB P&P M.6 Life Saving Emergencies was updated on 07-26-21, and states deputies shall carry naloxone on their person. This verbiage can now be found in SDSD DSB P&P M.48 titled "Naloxone Insurance and Storage". Jail Video Surveillance showed Granillo was pulled halfway out of her cell at approximately 2:07AM. SDSD records showed deputies tried to use smelling salts to wake Granillo without success. According to SDSD records, the first dose of naloxone was administered at 2:09AM, a second dose was administered at 2:11AM, and additional doses at 2:13AM, and 2:15AM. 9-1-1 was contacted at approximately 2:10AM. Jail Medical (two nurses) arrived at 2:12AM. According to interview with homicide detectives, deputies indicated Granillo had very shallow breathing and described it as "gasping" and a faint pulse on her neck. According to California Commission on Peace Officer Standards and Training -Basic Workbook Series Student Materials, titled "Learning Domain 34, First Aid &CPR", the training states if the victim has a pulse, is breathing, but unconscious, deputies should check for life-threatening conditions, and place the victim in the recovery position. In an interview with homicide detectives, a deputy stated she observed Granillo on the floor outside of her cell in the recovery position when she arrived at approximately 2:04AM. This was unable to be verified by jail video surveillance and BWC footage due to poor video quality and camera angles. When jail medical arrived, a nurse evaluated Granillo and stated she noticed Granillo "was kind of swallowing". The nurse stated it was unclear if she was breathing but she saw Granillo swallow, and thought she had a pulse. Oxygen was requested at approximately 2:14AM and again at 2:15AM. In BWC deputies can be heard several times asking if the oxygen is connected. A nurse determined Granillo no longer had a pulse and/or breathing and initiated CPR at 2:16AM. A nurse requested oxygen and an automated external defibrillator (AED). A nurse received the oxygen but not the AED. Paramedics arrived at 2:17AM. Paramedics stated they did not hear any air in the tube and requested to put her on airway. While there appeared to be an issue with the oxygen provided by detention facility medical staff, this was unable to be verified. CPR transferred from medical to sworn personnel at 2:20AM. Approximately 8-9 doses of naloxone were deployed. SDSD records showed at approximately 2:27AM, Granillo was transported to Sharp Grossmont Hospital where she underwent exams and testing. Granillo's medical results indicted anoxic brain injury and possible bowel perforation. Granillo underwent emergency exploratory surgery and was found to have a perforated prepyloric ulcer. The wound was repaired, and she was transferred to the Intensive Care Unit (ICU). Granillo's condition rapidly declined, and her family elected for Do Not Resuscitate Orders. Granillo was pronounced dead on 07-13-22. In the follow up investigation conducted by Homicide detectives, it was discovered there was an apparent intercom issue in House 3C. The evidence showed the intercom produced a symbol but did not chime. SDSD records showed two additional nurses arrived at House 3C but were not able to make entry after repeated attempts. The records indicated the additional nurses arrived at 2:13AM, and left at 2:16AM, returned at 2:17AM and left again at 2:19AM. Jail video surveillance showed the additional jail medical nurses returned again at 2:23AM and were able to gain access to the module when a deputy opened the door for them. Paramedics had already taken over care at that time. There was no way to determine if Granillo called for help using the intercom before discovery due to intercom issues. Furthermore, there was a delay in additional medical support response due to intercom issues and/or direct supervision staffing issues. While there was no one point of failure that led to Granillo's death, she should have never been booked into custody, there was known

intercom issues, potential oxygen issues, and the overall evaluation of Granillo when discovered appeared solely reliant on naloxone and smelling salts. Per SDSD P&P 4.23 titled Department Committees and Review Boards. The Critical Incident Review Board (CIRB) conducts a review of all in-custody deaths. According to the SDSD website, the releases "are synopses of reviewed incidents and any resultant actions or policy changes intended to improve our operations. In some instances, the information contained in these releases may be fragmentary or incomplete and are subject to update as information is verified or confirmed. The release of information related to a matter involving potential criminal prosecution or civil litigation may delay or limit the amount of information released until the conclusion of the case." The CIRB release for the death of Granillo stated, "The CIRB conducted a preliminary review of this incident on August 10, 2022, with no action items or policy recommendations at that time." The release also stated the cause and manner of death "are still pending the completion of the Medical Examiner's final report". In CLERB #22-053/Ornelas, CLERB made three recommendations to CIRB reviews which included: 1. Post Critical Incident Review Board (CIRB) Reviews on the SDSD website within 10 days of the review. 2. Update CIRB Reviews on the SDSD website within five days of obtaining applicable information. And 3. Include all contributing causes of death in the CIRB Review posted on the SDSD website. The policy response is still pending from the department. The evidence supports the allegation and the act or conduct was not justified.

2. False Arrest - Deputy 1 arrested Granillo.

   Recommended Finding: Sustained
   Rationale: SDSD records showed on 07-08-22, SDSD executed a search warrant in Escondido. During the execution of the warrant, Granillo was in apparent violation of a criminal protective order and found to be in possession of fentanyl. SDSD records indicated Granillo believed the restraining order was a "no negative contact" order. Furthermore, Granillo repeatedly asked Deputy 1 to double check the order as she was allowed contact, just no negative contact. According to SDSD records, the case was rejected by the District Attorney (DA). According to the response from the District Attorney, Granillo was correct the order was a "no negative contact" order. According to Emergency Booking Acceptance Criteria – COVID-19 Precaution effective 06-01-22, possession charges were non-bookable charges and should be processed as cite and release (non-custodial arrest). SDSD booking records did not indicate any possession charges for Granillo, and only showed the protective order violation as a charge. Granillo should have been cited and released for a fentanyl possession charge per COVID-19 Booking Criteria and Proposition 47. Based on the evidence, Granillo should have never been taken into SDSD custody for the Criminal Protective Order violation (custodial arrest). Deputy 1 provided confidential information during CLERB's investigation that was considered in arriving at the recommended finding. Deputy statements provided during the course of administrative investigations are deemed confidential by law and cannot be publicly disclosed. CLERB requested an interview with Deputy 1, but she exercised her right to decline participation in an interview pursuant to a long-standing agreement between CLERB and the Deputy Sheriff's Association. The evidence supports the allegation and the act or conduct was not justified.

3. Misconduct/Medical – SDSD Medical Staff did not provide medical care.

   Recommended Finding: Summary Dismissal
   Rationale: Attorney, Danielle Pena stated, "According to the attached documents, Ms. Granillo was not given proper medical treatment for withdrawals and other serious medical conditions." SDSD records showed Granillo went through an intake medical screening at booking. SDSD records showed Granillo had an anomaly in her body scans at intake. A medical report exam indicated the anomaly was fecal content versus potential foreign bodies. Per SDSD DSB P&P J.5 Suicide Prevention Practices for Incarcerated Persons & Detentions Safety Program set forth procedures for detention staff to identify those inmates who may be an elevated risk for self-harm or suicide. According to SDSD Medical Records, an Inmate Safety Program (ISP) gatekeeping assessment was performed at 7-08-22 at 1034AM. Granillo was placed on withdrawal protocol, and it was designated Granillo did not need to be placed into the Detentions Safety Program. According to SDSD medical records, a Clinical Opiate Withdrawal Scale (COWS) assessment indicated the patient was not assessed on 07-08-22 at 10:16AM and it was noted to reassess patient in 4 hours. A comprehensive detox screening was performed on 07-08-22 at 10:16AM. SDSD records showed Granillo was assessed again on 07-10-22 at 8:21 AM. SDSD medical records indicated Granillo was cleared to Jail Population Management Unit at 10:34AM on 07-08-22. SDSD medical records indicated crushed buprenorphine was

ordered starting morning of 07-10-22 but was first administered in morning of 07-11-22. According to SDSD medical records on 07-11-22 Granillo complained, "I feel like shit, I only got the meds now". 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. Medical treatment and care are made by jail medical staff and as such CLERB lacks jurisdiction to investigate further.

4. Misconduct/Procedure – Unidentified staff ignored Granillo's requests for medical intervention.

   Recommended Finding: Unfounded
   Rationale: Attorney, Danielle Pena also stated, "Ms. Granillo asked staff at Las Colinas for medical intervention, but her requests were ignored." SDSD records produced no documented grievances or sick call requests submitted by Granillo from 07-08-22 to 07-12-22. Furthermore, in an interview with homicide detectives, a deputy indicated on 07-12-22 at approximately 12:04AM, Granillo asked for a clean pair of pants. The deputy asked if Granillo was okay and she responded, "Yeah, I am okay. I am just withdrawing." The deputy also indicated on the following check at approximately 1AM, she asked Granillo if she was okay, and she nodded her head to indicate "yes". There was no evidence that suggested Granillo asked staff for medical intervention. The evidence showed the alleged act or conduct did not occur.

   POLICY RECOMMENDATION:

   1. It is recommended the San Diego Sheriff's Department (SDSD) mandate the direct supervision deputy notify Central Control to man intercoms and doors during a medical emergency.

DISCHARGES OF FIREARMS (1)

22-148/SPEARS (Inv. Klew)

1. Discharge of Firearm – SDSD Sergeant James Balderson III discharged his firearm, striking Spears.

   Recommended 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 11-28-22, detectives assigned to the Regional Auto Theft Task Force (RATT) attempted to recover a stolen vehicle which was occupied by Candace Spears. During the encounter, Spears exited the vehicle and pointed what appeared to be a handgun towards the detectives. Sergeant Balderson and a Chula Vista Police Department detective subsequently fired their weapons at Spears, striking her three times. Spears survived her injuries. The handgun which Spears pointed at the detectives was later determined to be a BB gun, or replica firearm. Per a Memorandum of Understanding (MOU), Countywide Protocol for the Investigation and Review of Officer-Involved Shootings and Other deadly Force Incidents, the San Diego Police Department (SDPD) was the primary agency assigned to investigate this use of force incident. Documents were received from the San Diego Sheriff's Department (SDSD) related to this incident which included the SDPD's investigation and the District Attorney's (DA) evaluation of this incident. No body worn camera (BWC) footage was in existence which showed the actual shooting occur. Penal Code (PC) Section 835a provided standards of when a peace office may use deadly force. 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." In this case, the evidence showed that Sergeant Balderson reasonably believed there was an imminent threat of death or serious injury to himself, and the other law enforcement officials present, and the use of force was justified. The CLERB considered numerous witness statements, including a statement made by Spears in which she indicated she tried to do a "police-assisted suicide" and acknowledgement she pointed a replica firearm at the Task Force members, when making this finding. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

POLICY RECOMMENDATION:

Regarding the lack of BWC footage in this case, current SDSD P&P Section 6.131, Body Worn Cameras, stated, "Deputies in plain clothes assignments are not required to wear BWC's; however, they will utilize a BWC when working or assigned to a uniformed patrol assignment or when donning an external vest in a plain clothes assignment if issued a BWC. Members of task forces are not required to wear BWC's while working in a task force capacity but may be directed to do so by a supervisor." In this case, Sergeant Balderson was assigned to a task force, therefore was not required to wear a BWC. It is reasonable that deputies in plain clothes or task force assignments, whose purpose it is at times to appear not as a law enforcement official, would not be required to wear a BWC. However, once that deputy puts on an external vest, donning insignia which identifies that deputy as a law enforcement official, it would seem reasonable the external vest also include a BWC. Fortunately, in this case, there were no concerns regarding the use of force. However, in many other cases, BWCs are an invaluable source of information when recommending a finding. Given the aforementioned, CLERB recommends the following to the San Diego Sheriff's Department:

1. Amend SDSD P&P Section 6.131, Body Worn Cameras, to require that deputies in plain clothes assignments, including members of task forces, are not required to wear BWC's; however, they will utilize a BWC when working or assigned to a uniformed patrol assignment or when donning an external vest.

USES OF FORCE RESULTING IN GREAT BODILY INJURY (2)

23-047/MACHADO (Inv. Chiesa)

1. Use of Force Resulting in Great Bodily Injury – Deputy Christopher Neufeld deployed his Sheriff's canine on Louis Akiva Machado, which resulted in Machado sustaining dog bites.

   Recommended Finding: Summary Dismissal
   Rationale: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. Deputy Neufeld is no longer an employee of the San Diego Sheriff's Department as of 06-02-22. 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, therefore the Review Board lacks jurisdiction and is unable to continue the investigation. The Review Board lacks jurisdiction.

23-154/MOELLER (Inv. Klew)

1. Use of Force Resulting in Great Bodily Injury – Deputy Balinger used a SDSD canine to apprehend Craig Moeller.

   Recommended 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 10-04-23 Deputies from the SDSD Poway Station were dispatched to a reported theft which occurred at a gas station. The reported subject, Craig Moeller, was alleged to have entered the gas station and steal a bottle of wine, and then walked out, entered a store employee's vehicle and stole a pack of cigarettes, before walking away. Deputy Balinger contacted Moeller, who was not compliant with directives, and a SDSD canine was used to assist in the apprehension of Moeller. As a result of the force used, Moeller sustained an injury. SDSD Policies and Procedures (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." Further, SDSD P&P, Addendum Section F, Use of Force Guidelines, regarding the use of canines, stated in part, "Canines are typically used in search scenarios, for deputy protection and for apprehension of fleeing subjects wherein this degree of force is justifiable. Canines certified and approved for department use may be used under the following

circumstances: For the protection of the handler, other law enforcement officers and citizens. To locate, apprehend or control a felony suspect when it would be unsafe for the deputies to proceed into the area. To locate, apprehend or control armed misdemeanor suspects." Involved Deputy reports as well as Body Worn Camera (BWC) footage was available to assist in making a finding in this case. The reports and BWC footage clearly showed Moeller acting in a manner that indicated an assault of the responding deputies was imminent. If Deputy Balinger had not used a canine to apprehend Moeller, this situation clearly could have escalated in which higher levels of force may have been used. A review of this incident, and current SDSD P&P, showed that the use of force by Deputy Balinger was justified. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

PRIORITY (5)

23-003/RUDDLE (Inv. Wigfall)

1. Misconduct/Procedure – Deputies 2 and 7 canceled Mitchell's social visit and/or video call.

   Recommended Finding: Action Justified
   Rationale: Alyssa Ruddle submitted a complaint on behalf of Jordan Mitchell while he was incarcerated at San Diego Central Jail. Ruddle reported that "SDSD personnel canceled all of Mitchell's calls and meetings." SDSD documentation showed that Mitchell wrote a grievance dated 12-16-22 where he reported Deputy 2 canceled his social visit after 30-minutes and stated he felt, "violated and profiled." A sergeant responded to the grievance and advised Mitchell that visits are 30-minutes and not 60-minutes. SDSD documentation showed that Mitchell wrote another grievance dated 12-29-22 where he stated his visit was canceled by Deputy 7 and felt he was "targeted." Lieutenant Cole responded to the grievance and stated that Mitchell's visit was canceled by the watch commander because the module was placed on security lockdown and found the deputy actions did not rise to the level of misconduct. According to DSB P&P, social visits and video visitations are a privilege, and may be suspended as part of a disciplinary action. Policy also states that visits are contingent upon conditions at the facility (i.e., emergencies, lockdown, etc.) all incarcerated persons will have the opportunity to receive two one-half hour visits weekly. In addition, according to the SDSD Website, social and video visits for San Diego Central Jail are 30 minutes in length. Evidence showed that deputies actions were in accordance with the SDSD's current policies and procedures and that the alleged conduct did occur but was lawful, justified, and proper.

2. Misconduct/Harassment – Deputy 5 "harassed" Mitchell.

   Recommended Finding: Not Sustained
   Rationale: Alyssa Ruddle submitted a complaint on behalf of Jordan Mitchell. She alleged that Deputy 5 "harassed and antagonized" Mitchell while he was incarcerated at San Diego Central Jail. Ruddle stated that the deputy told Mitchell he was a "shit dad" and "felt sorry for his kids." Ruddle stated she heard the deputy make these statements while she was on a video visit with Mitchell but failed to provide any dates of the alleged incident. Audio evidence was reviewed and there was nothing found that corroborated these allegations. SDSD P&P states that employees shall be courteous and tactful in the performance of their duties and that coarse, profane or violent language is generally prohibited. Deputy 5 responded to a Sheriff Employee Response Form (SERF) and provided a confidential statement that was considered in the outcome of these recommended findings. Given the lack of evidence, CLERB was unable to investigate this matter further. Also, a complaint packet and correspondence was sent to the aggrieved, but he did not respond to date. Although there was no evidence that Deputy 5 made these alleged statements, it is unknown if there were other alleged interactions between the deputy and Mitchell that may have violated policy. There was insufficient evidence to either prove or disprove the allegation.

3. Discrimination/Racial – Deputy 5 made "racist" remarks to Mitchell.

   Recommended Finding: Not Sustained

Rationale: Alyssa Ruddle submitted a complainant on behalf of Jordan Mitchell while he was incarcerated at San Diego Central Jail. Ruddle stated that Deputy 5 "made racist remarks" towards Mitchell and when the aggrieved told the deputy to stop, the deputy wrote him up. In review of SDSD documentation, there was only one mention of any racially correlated incidents. According to SDSD Incident Report dated 12-29-22, Mitchell received a rule violation where he was reportedly disrespectful to staff, made racial comments to deputies, and knocked food on the floor. SDSD P&P states that employees shall not express any prejudice or harassment concerning race, color, national origin, ancestry, etc. Policy states that such discriminatory acts will not be tolerated. Deputy 5 responded to a Sheriff Employee Response Form (SERF) and provided a confidential statement that was considered in the outcome of these recommended findings. In addition, Ruddle did not provide any dates or specific information about the alleged incident. Also, a complaint packet and correspondence was sent to the aggrieved, but he did not respond to date. Given the lack of information provided by the complainant, CLERB was unable to investigate this matter further. There was insufficient evidence to either prove or disprove the allegation.

4. Excessive Force – Deputies 1, 3-7 "beat-up" Mitchell.

Recommended Finding: Action Justified
Rationale: Alyssa Ruddle submitted a complainant on behalf of Jordan Mitchell while he was incarcerated at San Diego Central Jail. The complainant reported that Mitchell was "beat up" by several deputies and that Deputy 5 "slammed his face into the ground while he was in handcuffs." SDSD documentation showed that on 01-04-23, deputies were involved in a use of force incident with Mitchell. Deputy reports stated Mitchell was involved in a physical altercation with another incarcerated person (IP). Deputy 3 reported he secured Mitchell in handcuffs, escorted him out of the module and instructed Mitchell to walk inside the elevator, but he did not comply, tensed his muscles and yelled obscenities. Deputy reports stated Mitchell swung his left foot back and struck Deputy 3's right shin. Deputy 3 reported he took Mitchell down to the floor to gain control of him and Mitchell landed face down in the prone position but continued to tense his muscles. SDSD documentation stated deputies applied downward pressure to Mitchell's right temple, shoulders and ankles. Deputies also reported Mitchell actively resisted and spat on the floor, so a spit mask was applied to his head. Deputy 6 then applied leg chains on Mitchell's ankles, and he was placed on a medical gurney where he was evaluated and cleared by jail medical staff. Jail surveillance video was observed and corroborated deputy reports. SDSD Addendum F, Use of Force Guidelines states deputies may only use a level of force they reasonably believe is proportional to the seriousness of the suspected offense or the reasonable perceived level of actual or threatened resistance. The force used by deputies was necessary to gain control of Mitchell. Mitchell's behavior escalated from active resistance to assaultive behavior towards deputies. In addition, Deputy 5 reported he used downward pressure on Mitchell's temple, which is in compliance with SDSD Use of Force Policy. Deputy 5 responded to a SERF and provided a confidential statement that was considered in the outcome of these recommended findings. Evidence showed that the alleged conduct did occur but was lawful, justified, and proper.

23-045/APPENZELLER AND JACKSON (Inv. Chiesa)

1. Excessive Force – Deputies 1, 2, and 3 used force on Jackson.

Recommended Finding: Action Justified
Rationale: Appenzeller stated, "on 04-28-23 at 1PM, the guards (police) were doing head count on unit 4B when the inmates were outside of their cells when they got to my sons cell 121, there were 4 guards/police that pulled my son, Michael Anthony Jackson from his cell and took him under the stairs where there are no cameras and the inmates (witnesses) told (redacted) that from 1300-1320 the 4 guards/police held my son down and was beating him with their fist punching him in the face and tased my son Micheal several times." In an interview with CLERB intake investigator, Jackson stated he was told he was in the wrong for wearing shorts. Jackson failed to mention his shorts were not jail issued shorts, but handmade shorts made from a white jail issued t-shirt. According to SDSD records on 04-28-23 at approximately 1:35PM, Jackson was observed to be wearing altered jail issued clothing in the dayroom. According to SDSD DSB P&P L.1 titled, "Laundry Schedule", "Incarcerated persons may be issued facility specific clothing (e.g., sweatshirts, sleeping garments, shorts). The issuance and exchange of facility specific clothing will be detailed in facility green sheets." Furthermore, the policy states, "Incarcerated persons may be permitted to wear items other than

standard issued clothing, at the direction of a physician (e.g., medical shoes)." The facility green sheets for George Bailey Detention Facility for both L.1.G and I.47.G did not mention shorts. Furthermore, CLERB received confirmation via email from Division of Inspectional Services that GBDF does not issue shorts. Jackson was instructed by deputies to return to his cell and remove his makeshift shorts made of a white T-shirt. According to reports, Jackson returned to his cell but refused to remove the makeshift shorts and give them to deputies. Deputies attempted to secure Jackson's cell door, but Jackson quickly reached out to prevent deputies from closing it. According to reports, Jackson took a bladed stance with his fists clinched. Deputies attempted to handcuff Jackson, but he resisted and pulled away. Deputy 2 pulled Jackson to the floor. Jackson kicked Deputy 1 and punched Deputy 3. A use of force ensued. According to deputy reports, Deputies gave Jackson several commands to stop fighting and place his hands behind his back but he refused. Deputy 2 told Jackson to stop kicking and roll into his stomach and place his hands behind his back. A Conducted Energy Device (CED) was deployed (*see allegation 2*) and Jackson was secured. Jackson sustained a cut above his right eyebrow, redness and swelling to his face, and redness to his middle back. Jackson was evaluated by jail medical staff and cleared to go back to housing. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

2. Excessive Force – Deputy 2 tased Jackson.

   Recommended Finding: Action Justified
   Rationale: Jackson and Appenzeller alleged Jackson was tased by deputies. Per Addendum F-Use of Force Guidelines, Conducted Energy Devices (CEDs), "The CED is an intermediate force option. The CED is an electronic control device that is extremely effective for temporary immobilization of subjects. The CED produces 50,000 volts of electricity that cause involuntary muscle contraction and temporarily incapacitates a subject. As a force option, the CED shall only be used as a means of subduing and gaining control where there is an immediate threat justifying an intermediate level of force." In an interview with CLERB intake investigator, Jackson stated once he noticed he was bleeding, he tried to defend himself. Jackson stated once he tried to defend himself, he was tased. According to Deputy 2's report, "Due to Jackson's continued assaultive behavior, I armed my CED, and drive stunned him for approximately 5 seconds." Deputy 2 indicated the force was ineffective and Jackson had turned on his side and kicked towards Deputy 1. Deputy 2 instructed Jackson to stop kicking and roll onto his stomach, but he refused and continued to kick. Deputy 2 placed the CED on Jackson's lower back and drive stunned Jackson for approximately 5 seconds. The force was ineffective. Deputy 2 attempted to deploy CED probes into Jackson's back, but the CED malfunctioned and instead "arced" for approximately 5 seconds. Jackson rolled to his stomach and placed his hands behind his back and was able to be secured in handcuffs. The use of force was effective in gaining control of Jackson. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

3. Excessive Force – Unidentified deputy placed a knee on Jackson's temple.

   Recommended Finding: Not Sustained
   Rationale: Jackson stated, a deputy put their knee on his head and put as much pressure as they could on his temple area. SDSD records showed a use of force ensued after Jackson's refusal to remove jail altered clothing, however there was no evidence that showed deputies put pressure on Jackson's temple and/or head. The only mention of Jackson's head was the use of a spit sock (*see allegation 4*). There was insufficient evidence to either prove or disprove the allegation.

4. Misconduct/Procedure – Deputy 2 applied a spit sock to Jackson.

   Recommended Finding: Action Justified
   Rationale: Jackon stated, deputies entered the module and placed a spit sock over his head. SDSD policy Addendum Section F states, "Because of the inherent health risks, deputies may deal with spitting assaults/attacks on persons or property by use of a department approved "Spit Sock.'" The policy further states, "The Spit Sock will not be tightened in any manner to secure the mask around the prisoner's neck." According to Deputy 2's report, "to prevent bodily fluids from coming in contact with deputies, I placed a spit sock over his head." The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

5. Misconduct/Procedure – Deputies 1, 2, and 3 placed Jackson on a medical gurney.

   Recommended Finding: Action Justified
   Rationale: Jackson alleged deputies placed him on a gurney and strapped him very tight and he was unable to breathe. 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, Jackson was placed on a gurney in the recovery position, secured with safety straps, and transported to jail medical. SDSD records indicated Jackson was on the gurney for approximately 20 minutes. SDSD records indicated another deputy was assigned as the safety deputy to monitor Jackson's wellbeing while on the gurney. SDSD records produced photos following the use of force that showed Jackson strapped on the gurney. The photos showed Jackson on his side, there was no indication the straps were too tight around Jackson's body. The straps did not appear to be digging into Jackson's skin and/or body. SDSD records indicated Jackson sustained a cut above his right eyebrow, redness and swelling to his face, and redness to his middle back. Jackson was evaluated by jail medical staff and cleared to go back to housing. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

6. Misconduct/Procedure – Deputy 2 placed Jackson in administrative separation.

   Recommended Finding: Action Justified
   Rationale: Jackson alleged he was placed in "the hole" following the incident. According to SDSD records on 04-29-23, Jackson was placed into administrative separation. According to an incident report, Jackson has a long-documented history of negative behavior, and several incidents in which he did not follow directions. The incident report included several incidents of Jackson refusing to obey deputy commands, as well as the most recent incident of refusal to hand over the jail altered clothing. 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 (IAW) policy. On the administrative segregation form it was noted "continual failure to adjust and confirm to minimum standards." The evidence showed that the alleged act or conduct did occur but lawful, justified, and proper.

7. Misconduct/Procedure – Unidentified deputy housed Jackson in a cell with raw sewage.

   Recommended Finding: Not Sustained
   Rationale: Jackson alleged his cell was flooded and filled with feces for two days. According to SDSD records, Jackson was placed in Module 6A, cell 208 from 04-28-23 to 04-30-23. 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 GBDF. According to the Green Sheet for GBDF, "facility staff shall maintain a daily cleaning schedule to ensure all areas of the facility are disinfected. Deputies shall supervise in-custody workers, ensuring the cleaning is completed in a timely manner." According to the facility green sheet, "all housing units within the facility shall have access to a cleaning cart and cleaning supplies." The policy states all housing units within the facility shall have access to a cleaning cart and cleaning supplies. Furthermore, if necessary but deemed unsafe to provide cleaning materials to an in-custody individuals, the IP will be placed in dayroom and an in-custody worker will be

utilized to clean the cell. A review of all jail documents did not reveal any submitted complaints or grievances by Jackson that expressed any concerns or complaints about the cleanliness of any of the jail cells he was assigned to. Each facility has scheduled weekly hygiene inspections which are conducted by designated staff members. SDSD records produced hygiene inspection results sheets for Jackson's housing module. The hygiene inspection sheets showed cell 208 was inspected on 04-02-23, 04-09-23, 04-16-23,04-23-23, and 04-30-23. The hygiene inspection results indicated a passing score on the cell with no sanctions. The hygiene inspections were conducted in accordance with policy. There was insufficient evidence to either prove or disprove the allegation that unidentified deputies placed Jackson into an unsanitary jail cell.

8. Misconduct/Procedure – Unidentified jail staff placed Appenzeller on extended phone hold.

   Recommended Finding: Summary Dismissal
   Rationale: Appenzeller stated, "I called GBDF on 04-29-23 at 0900 am and was on hold for 45 minutes. I then called back 04-23 at 10am. I was transferred to medical and spoke to a lady who took my information; name, phone number, and inmate relation. I was told that they need a release of information for me to be able to speak to the nurse and get an update on my son Micheal's condition. I am now waiting 24 hours to call back from GBDF." Telephone calls are answered by Detention Processing staff who are non-sworn personnel. 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. CLERB has no authority to over the actions of detentions processing staff. Furthermore, CLERB has no jurisdiction over medical or medical staff, and as such CLERB has no authority to investigate further. The Review Board lacks jurisdiction.

23-059/SHOATE (Inv. Chiesa)

1. Misconduct/Procedure – Deputy 4 ordered Andie Shoate to terminate his phone call(s).

   Recommended Finding: Action Justified
   Rationale: In an interview with CLERB intake investigator, Shoate stated on 06-06-23 at approximately 4:50AM his tier was let out for breakfast. Shoate stated for the last month or two instead of eating breakfast he used the phone during this time. SDSD DSB P&P P.2 titled "Telephone access" establishes guidelines that permits incarcerated persons to use telephones during normal operating procedures. According to the policy, "Telephones will be located in areas accessible to incarcerated persons during dayroom or recreation time when they are allowed outside of their assigned cells or dorm living units." According to the Area Activities Report for Shoate's housing module, "dayroom/phone time" for Shoate's housing module on 06-06-23 occurred at 07:13AM, 1:00PM, 8:42PM. SDSD records showed Shoate's module was not in dayroom or "phone time" at 4:50AM and as such phone time was not permissible. Deputy 4 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. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

2. Misconduct/Intimidation – Deputy 4 removed Shoate from his cell.

   Recommended Finding: Action Justified
   Rationale: Shoate stated the deputy came to his cell and told him he was going to take him "somewhere he can write his own routine". SDSD records indicated Shoate was moved due to a rule violation and an anonymous letter placed in the grievance box indicating Shoate was planning on initiating a riot. Deputy 4 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. According to Addendum F-Use of Force Policy, De-escalation is defined 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 policy states the goal of de-escalation is to gain voluntary compliance of subjects to reduce or eliminate the need to use force on a subject. There was a preponderance of evidence that indicated Deputy 4 was justified in

moving Shoate. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

3. Excessive Force – Deputies 1-6 used force on Shoate.

   Recommended Finding: Action Justified
   Rationale: Shoate stated deputies entered his cell and hit him on his head and kicked him. According to Addendum F use of Force Guidelines, "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." The policy also states, "deputies shall not lose their right to self-defense by the use of objectively reasonable force to effect an arrest, prevent escape or overcome resistance." According to SDSD records, Shoate resisted deputies and disobeyed commands. Furthermore, SDSD records indicated Shoate was assaultive and continuously struck deputies. According to multiple deputy reports, Shoate refused multiple deputy commands to gather his items and leave his cell. SDSD records stated once SDSD deputies approached Shoate's cell, he took a fighting stance and told deputies "You're going to have to take me." According to multiple deputy reports, Shoate delivered closed hand fist punches to Deputy 4, Deputy 3, and Deputy 2. Deputy reports indicated Shoate continued to disobey deputy commands and be assaultive towards deputies. While there is no jail video surveillance inside the jail cell, there was a preponderance of evidence that showed Shoate ignored deputy commands. Deputy 4 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. Furthermore, Shoate's cellmate refused to provide a witness statement to recount what occurred. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

4. Excessive Force – Deputies 4 and 6 tazed Shoate.

   Recommended Finding: Action Justified
   Rationale: Aziz stated, "At about 5:30 AM jail detainees state that Andie Shoate was tazed repeatedly by officers." SDSD records showed Shoate was involved in a Use of Force (UoF) at approximately 4:45 AM. Per Addendum F-Use of Force Guidelines, Conducted Energy Devices (CEDs), "The CED is an intermediate force option. The CED is an electronic control device that is extremely effective for temporary immobilization of subjects. The CED produces 50,000 volts of electricity that cause involuntary muscle contraction and temporarily incapacitates a subject. As a force option, the CED shall only be used as a means of subduing and gaining control where there is an immediate threat justifying an intermediate level of force." According to Deputy 4's report, his strikes were ineffective, and he reached for his CED to "prevent Shoate from assaulting" him. Deputy 4 delivered the CED to Shoate's abdomen and his lower back. Deputy 6 pulled out his CED and deployed it at Shoate's stomach. Deputy 6 stated, at the time he pulled out his CED "Deputy 4 was struck in the face approximately 2-3 times. Deputy 3 grabbed the left side of Shoate and was met with closed fist punches to his face as he continued to hold on and gain control of Shoate". Deputy 4 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. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

5. Criminal Conduct – Deputy 4 "put a finger inside" Shoate's buttocks.

   Recommended Finding: Not Sustained
   Rationale: In an interview with CLERB intake Investigator, Shoate stated a deputy sexually assaulted him during the Use of Force. Shoate stated, "I was on the ground, first I felt like a rough brushing around my buttocks, the second time it was more noticeable what was going on. I felt a squeeze then I felt a finger go inside. Then the deputy said, "how does this feel? You're not so tough no more." It was the same deputy's voice, the deputy who asked me to get off the phone." SDSD P&P 2.54 titled "Sexual Harassment", states "Employees shall not participate in or allow behaviors or situations that they know or should know, constitute sexual harassment as outlined in state and federal law. Employees shall take swift action to stop the offensive

behavior or correct the situation. Employees shall not retaliate in any way against a complaining party or witness involved in sexual harassment allegations." SDSD P&P 6.127 states, "The Department shall comply with The Prison Rape Elimination Act (PREA) of 2003 by establishing a zero-tolerance standard for all forms of Sexual misconduct in detention facilities, patrol station lockups, holding cells or courthouses. Sexual misconduct includes but not limited to sexual abuse and sexual harassment between detainees/inmates, volunteers, contractors, Sheriff's employee or any outside source." SDSD records showed a Sexual Assault Nurse Examiner examined Shoate and forensic specimens were submitted to law enforcement. According to the PREA report, Shoate refused to have any anal swaps taken to be tested for DNA, and only DNA swabs were taken from different locations on Shoate's body. Furthermore, the report indicated, Shoate refused anal-rectal photographs and anoscopy. In the PREA report, Deputies 4, 3, 6, 1, and 5 all stated if any sexual assault occurred, they would have reported it. Deputy 4 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. Due to the incident occurring inside the cell, there was no jail video surveillance that captured the incident. There was insufficient evidence to prove or disprove the allegation.

6. Excessive Force – Unidentified deputies "hog-tied" Shoate.

   Recommended Finding: Unfounded
   Rationale: Aziz stated, "At about 5:30 AM jail detainees state that Andie Shoate was tazed repeatedly by officers. They also stated he was hog tied and left the facility bleeding." According to SDSD records Shoate was handcuffed and leg chains were placed around his ankles. Due to Shoate's size and the size of cell, three sets of handcuffs were used to connect Shoate's left arm to his right arm. Due to Shoate's large size and the deputies' inability to lift him, he was placed in a safety sled for transfer down the stairs. One set of handcuffs were removed prior to placement on safety sled. Shoate was placed on top of a gurney and was evaluated by Jail Medical staff in the rec yard then subsequently transferred to Sharp Chula Vista Hospital via ambulance. Once Shoate was evaluated by Jail Medical Staff, handcuffs were removed, and waist chains were placed on Shoate for ambulance transport. Furthermore, on 09-12-23, CLERB conducted a follow-up interview with Shoate at GBDF. In the interview, Shoate stated he was not hog-tied. He was placed in handcuffs and leg chains. This information corroborated what deputies stated in their reports. The evidence shows that the alleged act or conduct did not occur.

23-062/GUTIERREZ (Inv. Klew)

1. Excessive Force – Probation Officer (PO) 12 "forcefully removed" the aggrieved from his room on 10-20-22.

   Recommended Finding: Unfounded
   Rationale: The complainant, Olivia Gutierrez, stated, "On 10-20-22, (the aggrieved) was forcefully removed from his room. During the extraction, officers "slammed" (the aggrieved's) head on the ground…" Probation Department Institutional Services Policies (ISP) Section 514.3, Use of Force, stated, "Officers may use force as reasonably appears necessary in the performance of their duties, but excessive force shall not be used. Officers must use only that amount of force that appears reasonably necessary under the circumstances in order to gain control of the youth; protect and ensure the safety of youths, staff, and others; prevent serious property damage; prevent escape; obtain compliance with facility rules and staff orders; or ensure the institution's security and good order, or for other lawful purposes." Documents received from the Probation Department confirmed that while the aggrieved was housed at East Mesa Juvenile Detention Facility (EMJDF) on 10-20-22, a use of force incident occurred. However, a review of the associated reports, and CCTV (closed-circuit television) footage of the incident refuted the specific allegation that the aggrieved was (forcefully) removed from his room, or that his head was "slammed" on the ground. Further, based on the level of resistance observed through the CCTV footage, and the information noted in reports of this incident, the use of force which was observed was not identified as misconduct and appeared minimal. The evidence shows that the alleged act or conduct did not occur.

2. Excessive Force – Probation Officers 8, 9, and 10 "forcefully removed" the aggrieved from his room on 10-20-22.

Recommended Finding: Summary Dismissal
Rationale: See Rationale #1. POs 8, 9 and 10 were identified as being involved in the use of force incident occurring on 06-02-23. The Probation Department advised these POs separated from the Department prior to the completion of this investigation. CLERB Rules and Regulation Section 4.1, Complaints: Authority, stated, "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 Review Board lacks jurisdiction.

3. Misconduct/Procedure – Unidentified Probation staff delayed notification to Complainant Gutierrez of a use of force incident occurring on 10-20-22.

   Recommended Finding: Unfounded
   Rationale: Complainant Gutierrez stated she was not contacted following the use of force, until 10-24-23. ISP Section 514.6.2 Required Notifications, stated, "In addition to the notification of medical and mental health staff, the Division Chief or designee should ensure the parent or legal guardian of the youth is informed of any use of force, including the use of chemical agents." Probation Department contact records showed that an entry was made by PO 4 on 10-20-23 and 10-24-23 in which Complainant Gutierrez was contacted. It should also be noted the current "Required Notifications" policy does not specify a timeframe in which the parent/legal guardian notification needs to be made by. The evidence shows that the alleged act or conduct did not occur.

4. Misconduct/Truthfulness –Probation Officer 4 reported that the aggrieved received an "x-ray," when it did not occur.

   Recommended Finding: Unfounded
   Rationale: Complainant Gutierrez stated that PO 4 reported the aggrieved received an "x-ray," however, the aggrieved informed that he never received an "x-ray." Included in the documents received from the Probation Department were medical records related to the aggrieved. Specific health information cannot be disclosed; however, it does not appear that PO 4 was untruthful in their communication with Gutierrez based upon the documentation reviewed, and further, the medical records contradicted the allegation made. The evidence shows that the alleged act or conduct did not occur.

5. Excessive Force – Probation Officers 1, 2, 3, 5, 6, 7, 11 and 13 used force against the aggrieved on 06-02-23.

   Recommended Finding: Action Justified
   Rationale: Complainant Gutierrez stated, "(the aggrieved) did not want to go to recreation and he walked away from the officers. Four officers approached (the aggrieved) and he ran. The officers then 'threw' (the aggrieved) against a TV stand, took him down to the ground and proceeded to 'punch' him, with several other officers 'jumping' in and 'beating' on (the aggrieved)." Reports and CCTV footage of this incident were provided by the Probation Department. A review of the reports and CCTV footage showed that PO 9 used two "knee strikes" to gain control of the aggrieved. Additional, due to the aggrieved's significant non-compliance and continued struggle, POs 1, 2, 3, 5, 6, 7, 11 and 13 assisted at separate points throughout the incident by controlling the aggrieved's limbs, however no physical strikes or higher levels of force were reported or observed. Based on the level of resistance observed through the CCTV footage, and the information noted in reports of this incident, the use of force by the involved POs did not appear inappropriate, and further, that it was necessary in defense of themselves and to gain control of youth involved. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

6. Excessive Force – Probation Officer 9 used force against the aggrieved on 06-02-23.

   Recommended Finding: Summary Dismissal
   Rationale: See Rationale #5. PO 9 was identified as being involved in the use of force incident occurring on 06-02-23. The Probation Department advised PO 9 separated from the Department prior to the completion of this investigation. CLERB Rules and Regulation Section 4.1, Complaints: Authority, stated, "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 Review Board lacks jurisdiction.

7. Misconduct/Procedure – Unidentified Probation staff did not notify Complainant Gutierrez of a use of force incident occurring on 06-02-23.

   Recommended Finding: Action Justified
   Rationale: Complainant Gutierrez reported she was not notified of the use of force incident which occurred on 06-02-23 and involved the aggrieved. Call records received from the Probation Department noted that on 06-03-23 a SPO called and spoke with Gutierrez. The call log does not indicate that Probation Staff contacted Gutierrez on 06-02-23. As referenced in allegation #2, ISP Section 514.6.2, Required Notifications does not specify a timeframe in which the parent/legal guardian notification needs to be made. Gutierrez appeared to be correct in that she was not notified the day the incident involving the aggrieved occurred, however, this cannot be determined to be misconduct. The evidence shows that the alleged act or conduct did occur and was lawful, justified and proper.

8. Misconduct/Procedure – Unidentified Probation staff did not follow the aggrieved's "IEP" (Individualized Education Program).

   Recommended Finding: Summary Dismissal
   Rationale: Gutierrez reported the aggrieved's IEP directs that he be allowed to have the "time-out" alone, in his room. Gutierrez said this is the reason the aggrieved would not go to recreation, he needed a "time-out," and she reported the officers don't follow his IEP. Section 4: Authority, Jurisdiction, Duties and Responsibilities of CLERB, Subsection 4.1, Complaints: Authority, states, "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." IEPs are not completed by the Probation Department, and are a program set by a school district to identify supports and goals for a student. Depending on a student's needs, accommodations and supports may be made at a school site but would not be related to Probation Department Policy and Procedure. It should be noted, both use of force incidents, did not occur while the aggrieved was in school, and otherwise did not involve any school district employee**.** Given there is no prima facie of misconduct on behalf of the Probation Department, and that IEP are not under the jurisdiction of the Probation Department, The Review Board lacks jurisdiction.

9. Misconduct/Procedure – Unidentified Probation Officers left the aggrieved in "waist chains and handcuff" during visitation with Complainant Gutierrez.

   Recommended Finding: Action Justified
   Rationale: Gutierrez stated that during her visit with the aggrieved on 06-07-23, he was left in the waist chains & handcuffs. ISP Section 7.7.4.6, Special Security Methods, stated, "All (Administrative Separation) youth shall be placed in waist chains and leg shackles every time they exit their room." Based upon a review of current policy and Probation Department documents related to the aggrieved's classification, no misconduct can be identified. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

10. Misconduct/Procedure – Probation Officers 2, 3, 5, 7, 11, and 12 did not complete an incident report pursuant to Probation policy.

    Recommended Finding: Sustained
    Rationale: During the course of this investigation, it was noted that several Probation staff involved in the use of force incidents occurring on 10-20-22 and 06-02-23 did not subsequently complete an incident report. ISP Section 514.6, Reporting the Use of Force, stated, "Every staff use of force is an incident that shall be reported on the appropriate report form (15 CCR 1362). Any staff member who uses force and any staff directly observing the incident shall make a verbal report to a supervisor as soon as practicable and shall submit the appropriate documentation prior to going off-duty, unless directed otherwise by a supervisor. The documentation will reflect the actions and responses of each staff member participating in the incident, as

witnessed by the reporting staff member." Based upon a review of the associated policy, it was evident those involved staff should have completed an incident report detailing their participation in the incident, regardless of their level of involvement. Based upon this finding, a recommendation will be made to the Probation Department to provide a Training Bulletin regarding this matter. The evidence supports the allegation and the act or conduct was not justified.

POLICY RECOMMENDATIONS:

It is recommended that the San Diego Probation Department:

1. Amend Institution Services Policy Section 514, Use of Force, Subsection 514.6.2, Required Notifications, to include language which establishes a timeframe in which a parent or legal guardian notification shall be made, following a use of force incident.

2. Provide Institution Services staff a Training Bulletin which highlights Institution Services Policy Section 514, Use of Force, Subsection 514.6, Reporting the Use of Force, to include language which instructs that all staff who use force shall complete a written use of force report and that a separate involved staff's report shall not replace or substitute for their own written account of the incident.

23-087/ARMES (Inv. Klew)

1. Excessive Force – Deputy Probation Officer (DPO) 2 "slammed" the aggrieved's face into the ground.

   Recommended Finding: Unfounded
   Rationale: The complainant, Howard W. Armes, on behalf of Zechariah (aggrieved), stated, "(the aggrieved) was in a fist fight with another youth… When the alarm was sounded (the aggrieved) went to the cover position as soon as he saw the guards coming. (The aggrieved) was not resisting. Then (DPO 2) came into the room he grabbed (the aggrieved's) head forcefully slammed his face into the ground…" Documents received from the San Diego County Probation Department (Probation) confirmed that the aggrieved in this case was housed at the Youth Transition Campus (YTC) when the alleged incident occurred. Included in the evidence reviewed by CLERB were involved Deputy Probation Officer (DPO) reports, CCTV footage of the incident, as well as confidential response provided in several Probation Employee Response Forms (PERFs). The complaint reported that aggrieved in this incident suffered an injury because of the force used. Probation Institutional Services Policy Section 514.3, Use of Force, stated, "Officers may use force as reasonably appears necessary in the performance of their duties, but excessive force shall not be used. Officers must use only that amount of force that appears reasonably necessary under the circumstances in order to gain control of the youth; protect and ensure the safety of youths, staff, and others; prevent serious property damage; prevent escape; obtain compliance with facility rules and staff orders; or ensure the institution's security and good order, or for other lawful purposes." Ultimately, a review of the evidence did not show DPO 2 engaged in the alleged actions. Regarding the injury sustained by the aggrieved, it was unclear if DPO 2's actions would have caused the injury, as DPO 2 was not observed using force that was excessive. The evidence shows that the alleged act or conduct did not occur.

2. Misconduct/Discourtesy – DPO 2 "laughed" at the aggrieved.

   Recommended Finding: Not Sustained
   Rationale: The complainant alleged that after the aggrieved reported an injury, DPO 2 "laughed." Probation ISP Section 2, Personnel and Management, Subsection 2.4, Rules of Professional Conduct, stated, "It shall be the policy of this facility that all staff shall conduct themselves in an ethical and professional manner consistent with dedicated public service, as well as, the specific nature of individual job assignments. By setting a professional example through exemplary conduct and skillful execution of duties, staff will maintain positive public relations and provide a stable and safe environment for the youth under our care." Confidential statements made in PERF responses were considered when making a finding in this allegation. There was insufficient evidence to either prove or disprove the allegation.

3. Misconduct/Procedure – Unidentified Probation staff delayed dental treatment for the aggrieved.

Recommended Finding: Unfounded
Rationale: The complainant alleged that Probation Department personnel delayed dental treatment for the aggrieved. The complainant advised that when he called YTC on 08-02-23, after the use of force incident, he was informed by a nurse that Zechariah sustained an injury. Medical records were received from the Probation Department. The specific information contained in the medical records is protected health information and cannot be disclosed. However, a review of the medical records did show the aggrieved received treatment related to the injury in a timely manner. The evidence shows that the alleged act or conduct did not occur.

4. Misconduct/Procedure – DPOs 1 and 3 "ripped" pages from a notebook belonging to the aggrieved.

Recommended Finding: Actioned justified
Rationale: The complainant alleged, "(The aggrieved) told me that (DPOs 1 and 3) took his note book [*sic*] away from him and ripped the pages out where he had written down the entire incident of who was involved and how everything was going." PERFs were sent to both DPOs 1 and 3 to gather additional information about why the writings were removed, and that confidential information was used in determining a finding for this allegation. Based on a review of ISP Section 7, Behavior Control, Subsections 7.3.4.8, Personal Behavior, 7.1.5.4, Rules and Due Process, and 7.5.5, Officer Discretion to Counsel or Discipline, it was unclear if the writings were considered contraband or why a decision to remove them was appropriate. A request for the confiscated writings was made to the Probation Department, however, the requested material was unable to be located. While there is no policy violation which can specifically be identified, a review of this incident still caused concern. If the writings truly were the aggrieved's written account of an incident they were involved in, it would seem inappropriate the writings were confiscated. Considering the optics of this situation, it could be construed as an attempt to prevent a youth from providing information about an incident to their parent/guardian, legal counsel, or, in this instance, the CLERB. Additionally, it is noteworthy that 3 was involved in the use of force incident and was the DPO who confiscated the notebook, although was not the DPO alleged to have engaged in excessive force. As there did not appear to be specific policies in place, which would have prevented the writings from being removed, the action is justified. However, a policy recommendation will be made to remedy this issue. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

POLICY RECOMMENDATION:

1. It is recommended that the San Diego Probation Department create a policy mandating the safeguarding of a youth's contemporaneous writings pertaining to incidents occurring in the detention facility and procedures detailing the specific processes to safeguard the writings.

ROUTINE (4)

23-001/ACEDO (Inv. Klew)

1. False Arrest – Deputy Probation Officer (DPO) 1 submitted a felony bench warrant petition resulting in Daniel Acedo's arrest.

Recommended Finding: Action Justified
Rationale: The complainant, Daniel Acedo, alleged that DPO 1 falsely arrested him based on an invalid Bench Warrant. In his complaint to the CLERB, Acedo stated that DPO 1 obtained a "Probation Bench Warrant" but that DPO 1's "affidavit was not under penalty of perjury." Documents received from the Probation Department showed that Acedo was on a grant of Post Release Community Supervision (PRCS), and the Probation Department was the supervising agency. According to a Probation Department Court Report, by DPO 1, the Probation Department was informed that Acedo had been involved in a domestic violence incident with his girlfriend, in which Acedo was cited as a suspect. Additionally, the SDPD report, which was generated due to the incident, was cited by DPO 1 in the Court Report. DPO 1 continued that the

Probation Department was unsuccessful in contacting Acedo, and that his whereabouts were unknown in the community. The Court Report recommended a Bench Warrant be issued, as Acedo was alleged to have violated his PRCS terms and was unable to be located. The report was appropriately signed by DPO 1, approved by Supervising Probation Officer and reviewed by a San Diego Superior Court Judge. A Bench Warrant was subsequently issued, which was appropriately signed by a San Diego Superior Court Judge. A review of all the evidence in this case showed the Bench Warrant, which resulted in Acedo's arrest, was valid. No misconduct on behalf of DPO 1 could be identified. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

23-021/MILKOVITS (Inv. Klew)

1. False Arrest – Probation Officer (PO) 2 arrested Ryan Milkovits.

   Recommended Finding: Action Justified
   Rationale: In his complaint to CLERB, Milkovits stated that on 06-01-22, while at the Lighthouse Community Transition Center (CTC), he was "falsely arrested" for two "false probation violations." CA Penal Code (PC) Section 1203.2, Violation of Probation Terms, stated in part, "At any time during the period of supervision of a person (1) released on probation under the care of a probation officer pursuant to this chapter… if any probation officer, parole officer, or peace officer has probable cause to believe that the supervised person is violating any term or condition of the person's supervision, the officer may, without warrant or other process and at any time until the final disposition of the case, rearrest the supervised person and bring them before the court or the court may, in its discretion, issue a warrant for their rearrest." According to PO 2's Court report, the Probation Department arrested Milkovits for alleged violation of his conditions of mandatory supervision, specifically conditions 1b and 4b. Pursuant to PC Section 1203.2, the Probation Departments actions was lawful. Additionally, a Minute Order dated 07-28-22, indicated that Milkovits appeared in Court and was found by a Judge to not be in compliance with his conditions of mandatory supervision. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

2. False Arrest – PO 1 arrested Ryan Milkovits.

   Recommended Finding: Summary Dismissal
   Rationale: See Allegation #1. The Probation Department advised that PO 1 retired prior to the completion of this investigation. CLERB Rules and Regulation Section 4.1, Complaints: Authority, stated, "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 Review Board lacks jurisdiction.

3. Misconduct/Procedure – Unidentified POs lost and/or threw away Milkovits property.

   Recommended Finding: Unfounded
   Rationale: Milkovits alleged that when he was arrested, a notebook containing "over 40 pre-patent documents… each an invention with the date of invention, my name, confidentiality notice, invention title, invention diagram, and a technical description that I estimate the worth of each invention to be approximately $50,000; so the notebook is worth at least $2 million," was not released to him and/or lost. It should be noted, Milkovits provided no credible testimony which would indicate that this incident occurred. Additionally, this matter was addressed in CLERB case 23-018/Milkovits. In that case, it was determined that a notebook likely did not exist. Milkovits' allegation, signed under penalty of perjury, did not establish a prima facie showing of misconduct arising out of the performance of any probation officers' duties, and this allegation lacked merit. The preponderance of evidence showed that the alleged act or conduct did not occur.

4. Criminal Conduct – An unidentified PO "lied" in court.

   Recommended Finding: Unfounded
   Rationale: Regarding the violation of probation, Milkovits alleged that an unidentified PO "lied" in Court. Again, Milkovits did not provide any other testimony that indicate this incident occurred. As stated in Allegation #1, the violation of probation was a lawful action. Furthermore, the case was reviewed by a Judge

in Court, and Milkovits was found to be in violation of his terms of probation. Attempts were made to contact Milkovits to obtain further information regarding this allegation, however, no response was received. Milkovits' allegation, signed under penalty of perjury, did not establish a prima facie showing of misconduct arising out of the performance of any probation officers' duties, and this allegation lacks merit. The preponderance of evidence showed that the alleged act or conduct did not occur.

23-061/ARMSTRONG (Inv. Klew)

1. Misconduct/Procedure – Deputy Probation Officer (DPO) 1 issued Armstrong a probation violation.

   Recommended Finding: Action Justifed.
   Rationale: The complainant, Archie Tyrell Armstrong, alleged he was improperly placed in custody after DPO 1 determined Armstong was in violation of his probation terms. According to documents received from the Probation Department, on 12-22-21, Armstong was placed on a grant of formal probation for a period of 2 years. Records showed that Armstrong was arrested for violating his terms of probation on 02-09-23. CA Penal Code (PC) Section 1203.2, Violation of Probation Terms, stated in part, "At any time during the period of supervision of a person (1) released on probation under the care of a probation officer pursuant to this chapter… if any probation officer, parole officer, or peace officer has probable cause to believe that the supervised person is violating any term or condition of the person's supervision, the officer may, without warrant or other process and at any time until the final disposition of the case, rearrest the supervised person and bring them before the court or the court may, in its discretion, issue a warrant for their rearrest." According to documents received from the Probation Department, Armstrong was found to be in violation of several of his terms of probation, which ultimately prompted his arrest. A review of the evidence showed that the violation of probation submitted by DPO 1, and subsequent arrest of Armstrong, was a lawful action. Further, no misconduct could be identified after examining the evidence provided by the Probation Department. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

23-086/LEONARD (Inv. Aldridge)

1. Misconduct/Procedure – Deputy 3 conducted a traffic enforcement stop on Jason Thor Leonard.

   Recommended Finding: Action Justified
   Rationale: According to the complainant, on 04-08-23, he was pulled over by Deputy 3 allegedly due to "fake registration tags" on his vehicle. As noted in her written report, on 04-08-23, Deputy 3 was conducting routine patrol in the City of Poway when she observed a vehicle whose registration had expired in December of 2022. Deputy 3 performed a traffic enforcement stop on the driver of the vehicle, Jason Thor Leonard. Driving a vehicle with expired registration is an infraction with a fine. Observing Leonard driving a vehicle with expired registration gave Deputy 3 the authority to conduct a traffic enforcement stop. The evidence showed that the alleged act did occur, and it was lawful, justified and proper.

2. Misconduct/Intimidation – Deputy 3 "demanded" Leonard disclose information.

   Recommended Finding: Action Justified
   Rationale: According to Leonard's written complaint, he advised that Deputy 3 "demanded" he disclose information. According to Deputy 3's written report, during her interaction with Leonard, she asked him if he had made the vehicle registration sticker that was affixed to his vehicle. Leonard refused to comment and said, "I reserve the right to remain silent." In Leonard's complaint, he reported that he "*clearly invoked my right to remain silent on three separate occasions. Despite this, Deputy 3 persistently demanded that I disclose information about the incident. This continuous pressure to talk, even after asserting my rights, was intimidating, and undermined my constitutional protections*." There are certain situations where deputies may question individuals without Miranda. Miranda rights come into play when two key elements are present: custody and interrogation. If a person is not in custody or is not subject to interrogation, Miranda rights are not required. If a deputy is simply asking routine questions, gathering basic information, or engaging in general conversation with a person who is not in custody, Miranda warnings are not necessary. The evidence showed that the alleged act or conduct did occur, and it was lawful, justified and proper.

3. Misconduct/Truthfulness - Deputy 3 lied to Leonard.

   Recommended Finding: Unfounded
   Rationale: In his written complaint to CLERB, Leonard reported that Deputy 3 made fabrications of, "*false promises of citation. Initially, Deputy 3 informed me that I would receive a citation for the alleged offenses. However, without any justification, she proceeded to detain me in handcuffs. This action was disproportionate and created a hostile and destressing environment*." During his detainment, Deputy 3 conducted a records check on Leonard and learned he was a convicted felon. In review of Deputies 3's and 1's Body Worn Camera (BWC) recording of the interaction with Leonard, Deputy 3 informed Leonard he was being placed under arrest for having a false registration tag affixed to his license plate which warranted a misdemeanor citation. When Leonard was placed in handcuffs he informed deputies he had pepper spray in his possession. Leonard was a convicted felon in possession of pepper spray; a felony. As such, Leonard's misdemeanor citation escalated to a felony arrest. The evidenced indicated that Deputy 3 did not lie to Leonard. The evidence showed that the alleged act of Deputy 3 lying to Leonard did not occur.

4. Illegal Search & Seizure - Deputies 1, 2 and 3 searched Leonard's vehicle.

   Recommended Finding: Action Justified
   Rationale: In his written complaint to CLERB, Leonard report that "*while I was in custody, and without my consent, Deputy 3 proceeded to search my vehicle. This action is a clear violation of my fourth amendment rights, which protect against unreasonable, searches and seizures. The search was conducted without probable cause, consent, or a valid search warrant, she didn't even ask me if she could search my vehicle. There by violating my constitutional rights*." In California, if you are detained for a vehicle violation and subsequently arrested, the law enforcement officers generally have the authority to search your vehicle. This is based on the legal principle known as a search incident to arrest. When Deputy 3 made the lawful arrest, deputies were authorized to conduct a search of Leonard and the immediate area within Leonard's control for weapons, evidence, or to prevent the destruction of evidence. When the decision was made to impound and tow Leonard's vehicle, deputies gained the authority to conduct an inventory search of Leonard's vehicle. The deputies conducted a routine and non-intrusive inspection of the vehicle's interior and compartments. The principles governing searches incident to arrest in California align with the Fourth Amendment to the United States Constitution, which protects against unreasonable searches and seizures. The evidence showed that the alleged act or conduct did occur, and it was lawful, justified and proper.

5. False Reporting - Deputy 3 lied in her written report.

   Recommended Finding: Unfounded
   Rationale: Leonard alleged that "*Deputy 3 lied in her written report, stating she placed me under arrest for possession of false registration stickers, when she actually detained me, stating right now 'it's a citation*." *Justifying her search of my vehicle*." As noted in Deputy 3's written report and in her BWC recording, initially, Deputy 3 detained Leonard, pending further investigation. In her initial interaction with Leonard, Deputy 3 had reasonable suspicion that Leonard was in violation of the law. Reasonable suspicion is based on an inclination, opposed to having evidence. Often, reasonable suspicion leads a deputy to investigate further where they believe criminal activity was taking place. During that time pending her investigation, Deputy 3 detained Leonard. Upon further investigation, Deputy 3 developed probable cause that a crime had been committed. After closely inspecting the vehicle's registration sticker, Deputy 3 developed a clear and objective opinion, based on the circumstances and evidence, that suggested criminal activity. Deputy 3 articulated the chronological events that led from Leonard being detained, to him being arrested, based on the evidence against him. The evidence showed that the alleged act of Deputy 3 lying in her written report did not occur.

6. Misconduct/Procedure – SDSD "refused" BWC evidence to Leonard's attorney.

   Recommended Finding: Action Justified
   Rationale: Leonard alleged that the SDSD "refused" evidence to his attorney. Leonard reported "*The Poway Sheriff's are refusing to give my paid attorney the body cam footage from the incident on 04-08-2023 violating my sixth amendment constitutional rights*." According to SDSD Policy & Procedure Section 6.131 titled "Body

Worn Camera," the SDSD authorizes the use of Body Worn Camera (BWC) technology, with the goal of providing an additional layer of documentation for events, actions, conditions and statements made during law enforcement interactions. All audio, images and media associated with the BWC are the property of the San Diego County Sheriff's Department and will not be copied, released or disseminated in any form or manner outside the parameters of this policy without the express written release from the San Diego County Sheriff or his/her designee. All digital evidence collected using the BWC is considered property of the San Diego County Sheriff's Department and is for official use only. Accessing, copying, forwarding or releasing any digital evidence for other than official law enforcement use, or contrary to this procedure, is strictly prohibited. Moreover, an attorney would get access to BWC via the discovery process in court proceedings if there was an active case with the District Attorney filing charges. If the BWC does not fall into the category in which videos are normally released by the SDSD, per California law, (e.g. Critical Incident Reports, etc.) or the California Privacy Rights Act, then the attorney may contact the Sheriff's Records Division and submit a subpoena. SDSD records are released to certain authorities and with restrictions as set forth in accordance with policy and procedure. In California, the legal disclosure of records to attorneys is generally governed by various laws, including the California Public Records Act (CPRA) and other relevant statutes. CPRA is a state law that provides the public with the right to access government records. The CPRA includes exemptions that allow public agencies to withhold certain types of records from disclosure. In some cases, records may be disclosed pursuant to a court order or subpoena. Per the SDSD Records Division, CPRA requests are processed pursuant to GC 7923.600, which states: "State and local law enforcement agencies shall disclose the names and addresses of persons involved in, or witnesses other than confidential informants to, the incident, the description of any property involved, the date, time, and location of the incident, all diagrams, statements of the parties involved in the incident, the statements of all witnesses, other than confidential informants, to the victims of an incident, or an authorized representative thereof, an insurance carrier against which a claim has been or might be made, and any person suffering bodily injury or property damage or loss, as the result of the incident caused by arson, burglary, fire, explosion, larceny, robbery, carjacking, vandalism, vehicle theft, or a crime as defined by subdivision (b) of Section 13951, unless the disclosure would endanger the safety of a witness or other person involved in the investigation, or unless disclosure would endanger the successful completion of the investigation or a related investigation. However, this subdivision does not require the disclosure of that portion of those investigative files that reflects the analysis or conclusions of the investigating officer." If the attorney does not fall within the one of these categories, then the attorney's request is denied. Fundamentally, if the SDSD is unable to release a copy of the report, then the request for BWC is also denied. An attorney, representing a client, is only entitled to the same information their client is entitled to. For example, of the attorney is representing the victim of a crime, the attorney can receive the BWC. However, if the attorney is representing the suspect/arrestee, as was Leonard in this case, the request is denied per GC 7923.600. The evidence showed that the alleged act or conduct did occur, and it was lawful, justified and proper.

POLICY RECOMMENDATION:

In the complainant's letter, he reported that his attorney was unable to acquire the SDSD Body Worn Camera recording as evidence in his litigation against the department. SDSD P&P Section 6.131 does not articulate how one can obtain a copy of BWC recordings for legal proceedings. As such, CLERB recommends that:

1. The SDSD disclose how its records may be disclosed to an attorney, upon request, unless there are privacy and/or public safety exemptions which would prevent doing so.

SUMMARY DISMISSALS (7)

23-081/NIEVES (Inv. Chiesa)

1. Misconduct/Procedure – Deputy 1 did not enforce domestic violence restraining order.

   Recommended Finding: Summary Dismissal

Rationale: On 08-14-23, Jessica Nieves submitted a signed complaint to CLERB. On 12-28-23, in a telephone conversation with the CLERB assigned investigator Nieves expressed her desire to withdraw the complaint. CLERB received a signed withdrawal form on 12-28-23. Per CLERB Rules & Regulations 5.7 Withdrawal of Complaints states "a complaint may be withdrawn from further consideration at any time by a written notice of withdrawal signed and dated by the complainant. The effect of such withdrawal will normally be to terminate any further investigation of the complaint of misconduct, unless the Executive Officer or a Review Board member recommends that the investigation continue and the Review Board, in its discretion, concurs."

23-089/KOSZTOLNIK (Inv. Klew)

1. Misconduct/Procedure –Probation Officer (PO) 1 did not return Kosztolnik's phone calls

   Recommended Finding: Summary Dismissal
   Rationale: The complainant, Rita Kosztolnik, alleged the Probation Department would not return her phone calls regarding an individual on probation who was staying at a hotel property managed by Kosztolnik. Kosztolnik alleged that the individual who is on probation was staying at her hotel, engaging in illegal activities and was refusing to leave, and that she would report this to the Probation Department and not receive a response. During conversations with Kosztolnik, she advised she had in fact had several communications with PO 1 regarding the individual on probation. The information Kosztolnik provided contradicted the complaint submitted to CLERB. Additionally, a review of the contact records provided by the Probation Department showed that PO 1 did communicate with Kosztolnik, and advised Kosztolnik to call police if the individual on probation was committing a crime, and to follow up with Probation with the police report number. Ultimately, a review of the complaint, evidence provided by the Probation Department, and considering the information provided by Kosztolnik, a prima facie showing of misconduct could not be established. Kosztolnik was advised to file a separate complaint, if she believed any misconduct occurred separate of PO 1's communication. CLERB Rules & Regulations, Section 4: Authority, Jurisdiction, Duties and Responsibilities of CLERB, Complaints: Authority. Pursuant to the Ordinance, CLERB shall have authority to receive, review, investigate, and report on complaints filed against peace officers or custodial officers employed by the County in the Sheriff's Department or the Probation Department. This complaint is submitted for summary dismissal per CLERB R&R Section 15: Summary Dismissal, Summary Dismissal may be appropriate in the following circumstances: CLERB does not have jurisdiction over the subject matter of the complaint, as a prima facie case of sworn staff misconduct cannot be established.

23-095/DAWBER (Inv. Chiesa)

1. Misconduct/Procedure – Unidentified deputy "refused" to clean spilled milk.

   Recommended Finding: Summary Dismissal
   Rationale: On 08-10-23, Matthew Dawber submitted a signed complaint to CLERB. On 01-09-24, in a telephone conversation with the CLERB assigned investigator Dawber expressed his desire to withdraw the complaint. CLERB sent a withdrawal form on 01-09-24. Per CLERB Rules & Regulations 5.7 Withdrawal of Complaints states "a complaint may be withdrawn from further consideration at any time by a written notice of withdrawal signed and dated by the complainant. The effect of such withdrawal will normally be to terminate any further investigation of the complaint of misconduct, unless the Executive Officer or a Review Board member recommends that the investigation continue and the Review Board, in its discretion, concurs."

2. Misconduct/Discourtesy – Unidentified deputy refused to give Dawber Internal Affairs (IA) papers.

   Recommended Finding: Summary Dismissal
   Rationale: On 08-10-23, Matthew Dawber submitted a signed complaint to CLERB. On 01-09-24, in a telephone conversation with the CLERB assigned investigator Dawber expressed his desire to withdraw the complaint. CLERB sent a withdrawal form on 01-09-24. Per CLERB Rules & Regulations 5.7 Withdrawal of Complaints states "a complaint may be withdrawn from further consideration at any time by a written notice of withdrawal signed and dated by the complainant. The effect of such withdrawal will normally be to

terminate any further investigation of the complaint of misconduct, unless the Executive Officer or a Review Board member recommends that the investigation continue and the Review Board, in its discretion, concurs."

3. Misconduct/Procedure – Unidentified deputy refused to give Dawber his name.

   Recommended Finding: Summary Dismissal
   Rationale: On 08-10-23, Matthew Dawber submitted a signed complaint to CLERB. On 01-09-24, in a telephone conversation with the CLERB assigned investigator Dawber expressed his desire to withdraw the complaint. CLERB sent a withdrawal form on 01-09-24. Per CLERB Rules & Regulations 5.7 Withdrawal of Complaints states "a complaint may be withdrawn from further consideration at any time by a written notice of withdrawal signed and dated by the complainant. The effect of such withdrawal will normally be to terminate any further investigation of the complaint of misconduct, unless the Executive Officer or a Review Board member recommends that the investigation continue and the Review Board, in its discretion, concurs."

4. Misconduct/Procedure – SDSD housed Dawber in an unsanitary module.

   Recommended Finding: Summary Dismissal
   Rationale: On 08-10-23, Matthew Dawber submitted a signed complaint to CLERB. On 01-09-24, in a telephone conversation with the CLERB assigned investigator Dawber expressed his desire to withdraw the complaint. CLERB sent a withdrawal form on 01-09-24. Per CLERB Rules & Regulations 5.7 Withdrawal of Complaints states "a complaint may be withdrawn from further consideration at any time by a written notice of withdrawal signed and dated by the complainant. The effect of such withdrawal will normally be to terminate any further investigation of the complaint of misconduct, unless the Executive Officer or a Review Board member recommends that the investigation continue and the Review Board, in its discretion, concurs."

5. Misconduct/Procedure – SDSD staff did not provide clean laundry to Dawber.

   Recommended Finding: Summary Dismissal
   Rationale: On 08-10-23, Matthew Dawber submitted a signed complaint to CLERB. On 01-09-24, in a telephone conversation with the CLERB assigned investigator Dawber expressed his desire to withdraw the complaint. CLERB sent a withdrawal form on 01-09-24. Per CLERB Rules & Regulations 5.7 Withdrawal of Complaints states "a complaint may be withdrawn from further consideration at any time by a written notice of withdrawal signed and dated by the complainant. The effect of such withdrawal will normally be to terminate any further investigation of the complaint of misconduct, unless the Executive Officer or a Review Board member recommends that the investigation continue and the Review Board, in its discretion, concurs."

23-162/WALCHEFF (Inv. Bohan)

1. Misconduct/Procedure – San Diego Sheriff Department (SDSD) deputies responded to a call for service.

   Recommended Finding: Summary Dismissal
   Rationale: Walcheff stated, "Around 1700 on 04-11-21 two sheriff deputies came to the residence me and my family had leased and paid 3300 first, 3300 last and 3300 security to move into and informed us that the name on the lease was not consistent with the name of the registered homeowner. During this conversation one of the deputies asked if we had any firearms. Given the fact that my wife was prone to seizures and stuttering due to her advanced brain cancer… I voluntarily informed them of the registered and legal 9mm in the dresser drawer that should have a cable lock installed on it. The deputy retrieved the firearm, checked it and then returned it to my daughter's truck where my wife, daughter and then son in law were standing. We gathered our belongings and left…" Per CLERB Rules & Regulations, Section 4.1.2 Complaints: Jurisdiction, CLERB shall have jurisdiction in respect to all Complaints arising out of incidents occurring on or after November 7, 1990. Notwithstanding the foregoing, CLERB shall not have jurisdiction to take any action in respect to complaints received more than one year after the date of the incident giving rise to the complaint, except that if the person filing the complaint was incarcerated or physically or mentally incapacitated from filing a complaint following the incident giving rise to the complaint, the time duration of such incarceration or incapacity shall not be counted in determining whether the one year period for filing the complaint has expired. The exceptions do not apply in this case and therefore this case will be summarily dismissed per

CLERB R&R Section 15: Summary Dismissal, Summary Dismissal may be appropriate in the following circumstances: CLERB does not have jurisdiction because the complaint was not timely filed.

2. Illegal Search & Seizure – SDSD deputies "illegally" entered Zachary Walcheff's property.

   Recommended Finding: Summary Dismissal
   Rationale: Walcheff stated, "On 4/21/21 Sheriff deputies illegally entered the private property we had previously been moving from and immediately arrested me." See rationale #1.

3. False Arrest – Deputy 1 arrested Walcheff.

   Recommended Finding: Summary Dismissal
   Rationale: Walcheff stated, "The deputy that identified himself as Deputy 1 placed me under arrest without disclosing any reason for the arrest. I asked multiple times why I was under arrest and was told that he would talk to me about it back at the station." See rationale #1.

4. Misconduct/Procedure – Deputy 1 "demanded" information from Walcheff.

   Recommended Finding: Summary Dismissal
   Rationale: Walcheff stated, "Deputy 1 placed me in the patrol car, left for a moment and then returned. Upon his return he demanded to know the location of my wife's legal and registered 9mm. Under duress and with no concern of any illegal or criminal activity I informed him the Springfield was secured inside of our family truck (he never read me my Maranda rights which he admits in the reports also)." See rationale #1.

5. Illegal Search & Seizure – Deputy 1 searched Walcheff.

   Recommended Finding: Summary Dismissal
   Rationale: Walcheff stated, "Deputy 1 took my keys from my pocket without permission and without a search warrant or probable suspicion of any crime proceeded to seize the 9mm from my truck and arrest me without disclosing any reason for arrest." See rationale #1.

6. False Reporting – SDSD reported Walcheff was booked for "illegally cultivating marijuana."

   Recommended Finding: Summary Dismissal
   Rationale: Walcheff stated, "On 4/23/21 I was released from custody with no charges filed at that time. The release form said I had been booked on PC459 [Burglary] yet the sheriff reports from the same dates indicated I had been booked for illegally cultivating marijuana…" See rationale #1.

7. Criminal Conduct – Unidentified Sheriff personnel "hacked" Walcheff's CLET's record.

   Recommended Finding: Summary Dismissal
   Rationale: Walcheff stated, "In 5/2021 I purchased two firearms in the state of CA without issue. These purchases are the equivalent of a CA DOJ firearms eligibility check and clearly establish my rights to possess firearms in the state of CA as of 5/2021. On 8/22/22 someone hacked my clets and added a 17 year old felony conviction with a date of 2004/09/20 to my background. By doing so they over ran my legal gun licenses and entrapemented me with my legal guns and ammo." See rationale #1.

8. Misconduct/Procedure – The District Attorney filed charges against Walcheff.

   Recommended Finding: Summary Dismissal
   Rationale: Walcheff stated, "On 10/27/2021 The DA allegedly filed charges against me now including two pc28900 [Felon in possession of firearm] charges for "my statements in 2021 on body camera footage when I told deputies the location of my wife's legal 9mm on 4/11 and 4/21 of 2021." Per 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 the District Attorney 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.

9. False Arrest – El Cajon Police Department officers arrested Walcheff.

   Recommended Finding: Summary Dismissal
   Rationale: Walcheff stated, "On 1/11/2023 I was arrested like a bank robber after work at home on a multiple count felony warrant. I immediately made bail and have been fighting ever since." Per 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 El Cajon Police Department officers 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.

23-168/BAKER (Inv. Bohan)

1. Misconduct/Discourtesy – Sharp Rees-Stealy medical personnel were rude to Dr. Cooper Baker.

   Recommended Finding: Summary Dismissal
   Rationale: Dr. Baker stated, "I was seeking treatment for my son and myself on Friday evening after finishing work. I checked the Sharp Rees-Stealy urgent care portal online; the wait was short. I arrived at urgent care 30 minutes before closing, no line, was immediately greeted by the receptionist. A nurse was sitting next to the receptionist. I said, "how's it going…" and she replied in a loud surly tone 'you don't even want to know.' It was startling. Bewildered, I replied 'but I just asked...' She took that as some kind of attack, then informed me that the urgent care was actually already closed with a very rude tone of voice." 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 Sharp Rees-Stealy medical personnel 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 – Sharp Rees-Stealy medical personnel denied treatment to Baker.

   Recommended Finding: Summary Dismissal
   Rationale: Dr. Baker stated, "A doctor appeared and said that they were done seeing patients, but that I could drive to another Sharp Rees-Stealy urgent care. I reminded her that there was not enough time to get to one before 8, when they all actually close. She suggested I go to an E.R. for treatment instead." See Rationale #1.

3. Misconduct/Procedure – A Sharp Rees-Stealy Patient Advocate sent a "behavioral letter" to Baker.

   Recommended Finding: Summary Dismissal
   Rationale: Dr. Baker stated, "A Patient Liaison called me out of the blue, stating he went down to the front desk to find my information. He wanted my side of the story, then said I might be receiving a 'behavioral letter' because of all the profanity I used. In fact, I told the nurse I did not like her 'shitty' attitude only once. So, apparently it is ok for the staff to exhibit horrible behavior, but when I push back, I get a call and threats of an admonishing letter." See Rationale #1.

23-174/VIEHMAM (Inv. Bohan)

1. Misconduct/Procedure – Deputy 1 "omitted" critical evidence from a report.

   Recommended Finding: Summary Dismissal
   Rationale: Viehman stated, "Sheriff deputy 1 and his partner responded to a 911 call. I was the victim of a physical attack that night. The investigating officer, Deputy 1, wrote a police report that was omissive of critical evidence." The date of the incident giving rise to the complaint occurred on 09-08-22. CLERB Rules & Regulations, Section 4.1.2 Complaints: Jurisdiction, CLERB shall have jurisdiction in respect to all Complaints arising out of incidents occurring on or after November 7, 1990. Notwithstanding the foregoing, CLERB shall not have jurisdiction to take any action in respect to complaints received more than one year after the date of the incident giving rise to the complaint, except that if the person filing the complaint was incarcerated or physically or mentally incapacitated from filing a complaint following the incident giving rise to the complaint, the time duration of such incarceration or incapacity shall not be counted in determining whether the one year period for filing the complaint has expired. After follow-up with Viehman, they were unable to provide documentation/evidence that would show any exemptions that would be applicable in this case. Therefore, 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 as the complaint was not timely filed.

2. False Reporting – Deputy 1's report was not "based on fact."

   Recommended Finding: Summary Dismissal
   Rationale: Viehman stated, "Serious allegations have been brought against me as a result of this incident and I would request that CLERB review the investigative technique that Deputy 1 used the night of this incident. Deputy 1's report was incredibly biased and not based on fact." See Rationale #1.

3. Misconduct/procedure – Deputy 1 "coerced" and "corrected" a witness.

   Recommended Finding: Summary Dismissal
   Rationale: Viehman stated, "Deputy 1 can be seen on his own BWC [body worn camera] footage coercing a heavily intoxicated witness, and even goes as far as to correct her statements." See Rationale #1.

4. Misconduct/Truthfulness – Deputy 1's Body Worn Camera "contradicts" his report.

   Recommended Finding: Summary Dismissal
   Rationale: Viehman stated, "Deputy 1 was dishonest in his report, and his own body worn camera footage contradicts what his report says. I consider this to be gross misconduct." See Rationale #1.

24-002/RODRIGUEZ (Inv. Bohan)

1. Misconduct/Procedure – Oceanside Police officers responded to a welfare call.

   Recommended Finding: Summary Dismissal
   Rationale: Rodriguez stated, "On 12/11/23 officers showed up to my house, me and my daughters were in a peaceful manner and they claim someone had call having welfare concerns about my daughter." 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 Oceanside PD and the DDA do not fall under CLERB jurisdiction. Therefore, this case 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 – Oceanside Police officers questioned Rodriguez' daughters.

Recommended Finding: Summary Dismissal
Rationale: Rodriguez stated, “They started to ask them questions then I was call to go outside and I was arrested no physical evidence or and evidence.” See Rationale #1.

3. False Arrest – Oceanside police officers “unlawfully” detained and arrested Rodriguez.

   Recommended Finding: Summary Dismissal
   Rationale: Rodriguez stated, “I was falsely accused and unlawfully arrested and unlawfully detained for 273.A(b) when officers showed up to my house.” See Rationale #1.

4. Misconduct/Procedure – The Deputy District Attorney (DDA) obtained a “no contact order.”

   Recommended Finding: Summary Dismissal
   Rationale: Rodriguez stated, “On my first appearance hearing my maiden last name was call inside the courtroom and DDA ask for no contact order before my release of no bail for having a good record. My legal name has been cleared of all charges against me but my maiden name is set for trial, because I didn’t accept their plea bargain to plead guilty for child danger and cruelty and after 26 classes case could be dismissed.” See Rationale #1.

5. Misconduct/Retaliation – Oceanside Police officers “profiled” Rodriguez.

   Recommended Finding: Summary Dismissal
   Rationale: Rodriguez stated, “I’m upset because I had been profiled from officers who have a bad personal opinion of me and it was done as retaliation for dislikes of me. I had history having incidents with same officers when they were still in training or probation period, I had corrected theirs mistakes and put them in their place. This officers just had earn their badge so I was a big target for them officers went to my house and arrested me with false accusations and became an unlawful arrest and unlawful detention.” See Rationale #1.

6. Misconduct/Procedure – An Oceanside Police officer changed Rodriguez’ last name.

   Recommended Finding: Summary Dismissal
   Rationale: Rodriguez stated, “My case was dismissed but Oceanside officer show up to my court hearing and didn’t allow the dismissal of the charges and somehow changed my legal last name to my maiden last name. This way my case would stay open and ask the judge for no contact order.” See Rationale #1.

7. Misconduct/Procedure – Oceanside Police officers violated Rodriguez’ civil rights.

   Recommended Finding: Summary Dismissal
   Rationale: Rodriguez stated, “I’m so disappointed that officers that we trusted can act in this way. My relationship with kids is ruined and for them believe I did something wrong, I’m innocent of everything but now I’m also a victim of civil rights.”

End of Report