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County of San Diego

CITIZENS' LAW ENFORCEMENT REVIEW BOARD

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www.sdcounty.ca.gov/clerb

REGULAR MEETING AGENDA
Tuesday, February 13, 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. **MINUTES APPROVAL (Three minutes)** (Attachments A1, A2, and A3)

4. PRESENTATION/TRAINING (15 minutes)

a) CLERB Investigations Process by CLERB Supervising Special Investigator Lynn Setzler

5. EXECUTIVE OFFICER'S REPORT (Five minutes)

a) Overview of Activities of CLERB Executive Officer and Staff

b) Workload Report – Open Complaints/Investigations Report (Attachments B1, B2, and B3)

c) Case Progress and Status Report (Attachments C1, C2, and C3)

d) Executive Officer Correspondence to Full CLERB (Attachment D)

e) Policy Recommendations Pending Response, Listed by Department in Order of Date Sent to Department

Sheriff's Department (6)

i. Provision of Eviction Documentation in Threshold Languages
Recommendation Sent to SDSD on 10-23-22

- Create and provide an additional notice when posting or serving a "Notice to Vacate" to include a summary of interpreter services offered by the County of San Diego. Further, the notice should include information on how to access a summary of eviction timelines and processes, translated in the eight languages the County of San Diego has identified as having a substantial number of limited English-speaking persons.

ii. 21-117 / Tuck
Guidelines for Handcuffing, to Include Double-Locking Handcuffs
Recommendation Sent to SDSD on 12-16-22

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

iii. Publicly Release Reviews Conducted by the Critical Incident Review Board (CIRB)
Recommendations Sent to SDSD on 02-03-23

- Upon completion of the Critical Incident Review Board (CIRB) proceedings of an in-custody death, publicly release the CIRB Final Report.
- If unwilling to release the CIRB Final Report, consider establishing a separate public process for internally reviewing deaths and making necessary changes, as recommended in California State Auditor (CSA) Report 2021-109 entitled, "San Diego Sheriff's Department."
- Clarify the role of CIRB, specifically reconciling what is listed on the SDSD website with SDSD P&P Section 4.23. Is CIRB's purpose to assess "civil exposure" and avoidance of "potential liability…in the future," is it to make the facilities safer for all, or is it both?
- Codify any implemented changes into SDSD P&P Section 4.23.

Probation Department (0)

i. None

f) Policy Recommendation Responses

Sheriff Department (1)

i. Search or Scan All Persons Entering Detention Facilities (Attachment E)
Recommendation Re-Submitted to SDSD on 01-18-23
- 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.

Probation Department (0)

i. None

6. BOARD CHAIR'S REPORT (Five minutes)

7. NEW BUSINESS (45 minutes)

a) Discuss San Diego Sheriff's Department Response to CLERB's Policy Recommendation to Search or Scan All Persons Entering Detention Facilities, to Include Staff (Attachment E)

b) Review and Approve Draft Letter of Concern to San Diego Sheriff's Department re: Excessive Number of Rounds Fired by Deputies During Uses of Deadly Force (Attachment F)

c) Review and Approve Draft Letter of Concern to San Diego Sheriff's Department re: Communication Failures During #22-012/Talevara (Attachment G)

d) Approve Proposed Revisions to Administrative Code and CLERB's Rules and Regulations to Forward to the Board of Supervisors (Attachment H)

8. UNFINISHED BUSINESS (Five minutes)

a) Update: CLERB Detention Facility Inspection Process and Guidelines

b) Update: CLERB Jurisdiction Expansion over Medical Service Providers

c) Update: Probation Department Issues Detailed in October 2023 CLERB Executive Officer Report

9. BOARD MEMBER COMMENTS (Five minutes)

10. SHERIFF/PROBATION LIAISON QUERY (Five minutes)

11. CLOSED SESSION: TIME CERTAIN – 8:00 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 (5)

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 (3)

22-026/SCHUCK (Inv. Aldridge)

1. Death Investigation/Drug Overdose – William Hayden Schuck died while in the custody of the San Diego Sheriff's Department on 03-16-22.

   Recommended Finding: Sustained
   Rationale: William Hayden Schuck was incarcerated at the San Diego Sheriff's Department (SDSD) San Diego Central Jail (SDCJ). According to jail documents, on the night of 03-10-22, William Hayden Schuck was arrested by San Diego Police Department police officers after he was involved in a motor vehicle accident. He was arrested for suspicion of driving under the influence of drugs, possession of a firearm while under the influence of a controlled substance, unregistered person carrying a loaded firearm, carrying a loaded, concealed firearm on his person, possession of a manufactured or assembled a firearm without a serial number, possession of a large capacity firearm magazine, and possession of narcotic controlled substance. Schuck was transported to the SDCJ where he was incarcerated for approximately six days. On 03-16-22, he was found down and unresponsive in his jail cell. Upon being discovered, Sheriff deputies and jail medical/health staff were summoned to the scene and initiated life-saving measures. Paramedics were summoned to the jail and took over life-saving efforts. Despite medical intervention, Schuck failed to respond, and his death was pronounced on scene. The Sheriff's Department Homicide Unit responded to the jail to investigate the death. Schuck was subsequently transported to the San Diego County Medical Examiner's Office and an autopsy was performed. The Medical Examiner determined Schuck's cause of death to be complications of cocaine and methylenedioxymethamphetamine (MDMA) toxicity, with peptic ulcers being a contributing factor. The manner of death was accident. Toxicology testing revealed positive results for amphetamines, cannabinoids, cocaine metabolites, MDMA, and Tetrahydrocannabinol (THC). According to a review of jail documents and jail surveillance video recordings, safety/security checks were performed in a timely manner and in compliance with SDSD P&P. The evidence indicated that Schuck was properly classified upon his entry into the SDSD jail system after his arrest. Upon being discovered unresponsive, sworn personnel expeditiously responded and immediately initiated life-saving measures. Though it was unknown how Schuck obtained the illicit drugs, the evidence indicated that Schuck partook of illicit drugs while he was in the custody and under the care of the SDSD. 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." 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 Schuck initially stated, "The CIRB conducted a preliminary review of this incident on May 18, 2022. There were no policy changes or action items identified during that review." The San Diego County Medical Examiner's Office conducted an independent investigation and post-mortem. Schuck tested positive for cocaine during a presumptive test. At the time of the CIRB report, the cause and manner of death were still pending the completion of the Medical Examiner's final report. On 05-10-23, the CIRB conducted its final review of this incident and updated the report with the following action items listed: Item #1 – The circumstances of the incident were referred to the Sheriff's Internal Affairs Unit for review. 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. At the time of this investigation and this report, the policy response is still pending from the department. The evidence supported the allegation, and the act or conduct was not justified.

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

   Recommended Finding: Sustained
   Rationale: Schuck's cause of death indicated that he partook of illicit drugs shortly before the time of his death. The timeframe for cocaine and ecstasy to metabolize in the body can vary depending on factors such as the individual's metabolism, the dose ingested, and the frequency of use; however, cocaine is metabolized relatively quickly in the body. MDMA is metabolized at a slower rate compared to cocaine. It was noted that individual factors, such as liver function and hydration levels, may also affect the metabolism and elimination of these drugs from the body. Nonetheless, the evidence indicated that Schuck partook of the illicit drugs within the approximate six days of his incarceration, while he was in the custody and under the care of the SDSD. Though it was unclear how and when Schuck partook of the illicit drugs, the evidence supported the allegation, and the act or conduct was not justified.

3. Misconduct/Procedure – SDSD staff failed to recognize and/or respond to IP Schuck's medical needs.

   Recommended Finding: Sustained
   Rationale: Upon the review of all evidence in this case, to include videos and records, it was clear that, at the time of Schuck's incarceration and subsequent death in early 2022, there existed a culture in which deputy sheriffs either did not recognize or consider the impact of an incarcerated person's obvious medical issues or, if recognized or considered the impacts, simply pawned those responsibilities off onto medical personnel. In review of the numerous jail surveillance video recordings of Schuck's interactions with staff during his incarceration, it was noted that his health deteriorated over the course of his imprisonment. Jail surveillance video recordings depicted Schuck exhibiting an unsteady gait, loss of balance, collapsing onto the floor, and his appearance became increasingly disheveled. Jail medical/health staff and deputies noticed that Schuck had developed bedsores to his back, buttocks, and thighs, and at some point, he had unexplained bruising to his forehead and chin, and blood stains on his soiled white t-shirt. On 03-15-22, before going to court, Schuck informed jail medical staff, in the presence of deputies, that he had taken drugs; however, he did not receive any follow-up treatment, but was taken to court for his arraignment. In the homicide detective's audio recorded interview with the nurse who assessed Schuck, the nurse acknowledged that Schuck's jailed issued clothing was "soaked with water" [sweat] and that he had wounds, which the nurse cleaned. Schuck informed the nurse that he "took acid," and the nurse responded by scheduling Schuck for a wellness check-up the following day. Schuck's medical emergency was not recognized or addressed. It was unclear what occurred when Schuck went to court; however, court documents stated that the court referred Schuck to jail medical to "be screened for medications," which indicated that the court had a concern for Schuck's wellbeing. Upon returning to the jail from court, two to four deputies used arm guidance to escort Schuck off the transportation bus and back to his court holding cell. At one point, an unidentified deputy assisted Schuck with holding him up by his clothing. Schuck leaned again walls and slumped to the floor three times before he made it back to his court holding cell. While en route from court holding to his housing unit, Schuck was escorted by deputies who witnessed him collapse three times. Schuck was not escorted to medical. Evidence suggested that jail medical staff who assessed Schuck were unfamiliar with the appropriate protocols for handling Schuck's medical situation. Sworn staff failed to recognize, prioritize and respond effectively to Schuck who was in obvious medical distress. According to SDSD DSB P&P Section M.5 titled "Medical Emergencies," all facility staff shall be responsible for taking appropriate action in recognizing, reporting or responding to an inmate's emergency medical needs. Medical records were obtained from the jail and were reviewed. That information cannot be disclosed due to the Health Insurance Portability and Accountability Act (HIPPA) which protects the individual's sensitive health information. The evidence indicated that the SDSD failed to take appropriate action in recognizing and responding to Schuck's emergency medical needs, which underscored the critical importance of prompt and effective response. The evidence supported the allegation, and the act was not justified.

4. Misconduct/Procedure – Deputy 1 failed to recognize an anomaly in IP Schuck's body scan imagery.

Recommended Finding: Not Sustained
Rationale: During Schuck's intake process, deputies performed a pat down search and conducted a body scan of Schuck. A deputy conducted a search of Schuck's person and clothing for weapons and contraband. Schuck was then placed onto the body scanner machine. Schuck went through the body scanner approximately three times and Deputy 1reviewed the body scan image for a reasonable amount of time. According to the homicide report, the initial body scan showed some type of anomaly; there appeared to be a foreign object in Schuck's abdomen area. A "potential balloon size foreign object" was noted in Schuck's scan. The unknown object was determined to be a an "air void" or "air pocket." According to a training provided to deputies, an anomaly is any abnormality, inconsistency, or a non-human shape. The training suggested any differences that are not consistent on both sides of the body would also be an anomaly. According to SDSD DSB Section I.50 titled "Body Scanner and X-Rays," body scan imaging technology is used to produce an image revealing the presence of contraband concealed on or inside a person. Body scans shall be completed as part of the Intake Search of persons. In the event an anomaly appears within a subject's body, the deputy conducting the scan will inquire with the arrestee to identify the anomaly. The suspicion or concern, or lack of, of an anomaly in a body scan is the opinion of the scanner/viewer and is based on their training and experience. Deputy 1provided information during CLERB's investigation that was considered in arriving at the recommended finding, however, that information is privileged, and cannot be publicly disclosed. Absent information provided by an independent witness to the incident or additional video or audio recordings of the interaction, there was insufficient evidence to prove or disprove the allegation.

5. Misconduct/Procedure - SDSD failed to house IP Schuck within a reasonable timeframe.

   Recommended Finding: Action Justified
   Rationale: During this investigation, it was noted that Schuck remained in the booking status for approximately six days. Usually, after an incarcerated person is confined into the jail, they undergo the booking process and are transferred to housing within a day or two. It was noted that Schuck was arrived at the jail on 03-10-22 but was not housed until 03-16-22. It was learned from a Department Information Source that that COVID protocols were still in effect at the jail during this time. As such, changes were made to the jail's housing plan and medical's clearance criteria to complete a quarantine process. Newly incarcerated persons were quarantined/isolated for five days per the SDSD Medical Service Division's COVID protocols to incorporate appropriate management of incarcerated persons based on the needs and security of the facility. The evidence showed that the alleged act did occur, and it was lawful, justified and proper.

6. Misconduct/Medical - Jail medical/health staff failed to act after IP Schuck informed them that he used illicit drugs.

   Recommended Finding: Summary Dismissal
   Rationale: During this investigation, it was noted that a jail medical/health staff member failed to act after Schuck informed him that he partook of illicit drugs. Medical records were obtained from the jail and those records were reviewed; however, that information cannot be publicly disclosed due to the Health Insurance Portability and Accountability Act (HIPPA) which protects the individual's sensitive health information. Additionally, the nurse's audio recorded statement to homicide detectives regarding his medical treatment, or lack of, was reviewed. Health Services staff members are not sworn staff. 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 lacks jurisdiction to investigate medical treatment and care by jail medical/health staff.

7. Misconduct/Procedure - Deputy 2 failed to provide IP Schuck with a meal.

   Recommended Finding: Sustained
   Rationale: During this investigation, it was noted that Schuck was not provided a dinner meal on the evening of 03-15-22. In review of jail surveillance video recordings, Deputy 2 distributed meals to the incarcerated persons who were housed in the court holding cells. As Deputy 2 distributed dinner meals to the IPs in their individual cells, Deputy 2 walked past Schuck's cell without offering him a dinner meal. According to California Title 15 Minimum Standards, Article 12 titled "Food," subsection 1240 titled Frequency of Serving, food shall

be served three times in any 24-hour period. According to SDSD DSB Section K.1 titled "Provisions of a Nutritionally Adequate Diet," all inmates [incarcerated persons] shall be provided a diet, which meets or exceeds Title 15 regulations. Per SDSD DSB SDCJ Green Sheet K.15.C.1 titled "Serving Times and Distribution of Meals," incarcerated persons are scheduled to be served dinner between 4:00om and 5:00pm. Deputies will ensure each inmate is given a meal. Deputy 2 provided information during CLERB's investigation that was considered in arriving at the recommended finding, however, that information is privileged, per the Peace Officer Bill of Rights (POBR), and cannot be publicly disclosed. The evidence supported the allegation, and the act was not justified.

8. Misconduct/Procedure - Deputy 2 failed to notate that Schuck refused his meal.

   Recommended Finding: Not Sustained
   Rationale: When an incarcerated person refuses a meal, deputies document the refusal in the Jail Information Management System (JIMS) computer system. Deputies access the JIMS Area Activity Log to record routine and emergency situations involving inmates and overall housing unit activities. The log entries are mostly related to the jail's obligations under California Title 15 Minimum Standards, and it is a way of documenting activities and events that occur during shifts to use for possible future reference. According to SDSD DSB P&P Section I.21 titled "Housing Unit Area Activity Log," deputies shall maintain daily shift records of pertinent information regarding incarcerated persons and their activities. In review of jail documents, there were no entries notating that Schuck refused his dinner meal on 03-15-22. There was a log entry made by a different deputy who noted that Schuck refused his breakfast meal on 03-16-22. Deputy 2 provided information during CLERB's investigation that was considered in arriving at the recommended finding, however, that information is privileged per the Peace Officer Bill of Rights (POBR) and cannot be publicly disclosed. There was insufficient evidence to either prove or disprove the allegation that Deputy 2 failed make a computer entry that Schuck refused his meal.

9. Misconduct/Procedure - SDSD failed to provide IP Schuck with a bed, mattress, and/or linens.

   Recommended Finding: Sustained
   Rationale: During this investigation, and in review of jail surveillance video recordings and other evidence, it was noted that Schuck was not provided with a bed, mattress, blankets, towels, or sheets for the first six days of his incarceration. At the time of Schuck's incarceration, COVID protocols were implemented. As such, the SDSD made provisions for newly IPs to be isolated/quarantined before they were placed in housing units. A Department Information Source explained that IPs were kept in the cohort group with other incarcerated persons who had the same booking date and were quarantined/isolated together for five days. The individuals would remain in the same holding cell throughout the booking process and the quarantine process. As the cases of COVID-19 arose, bed space and housing availability became limited. Due to the limited bed space and housing availability, IPs remained in the court holding cells. During a scene investigation of the SDCJ court holding cells, it was noted that the court holding cells were equipped with a wall-mounted wooden bench and a wall-mounted combination sink and toilet. The court holding cells are not considered housing cells; however, that was where IPs were placed (housed) for days while they completed the quarantine process. While housed in the court holding cells, IPs were not provided with a bed, a mattress, blankets, towels, or sheets. According to California Title 15 Minimum Standards, Article 14 titled Bedding and Linen, section 1270 titled "Standard Bedding and Linen Issue," the standard issue of clean suitable bedding and linens, for each inmate entering a living area who is expected to remain overnight, shall include, one serviceable mattress, one mattress cover or one sheet, one towel, and one blanket or more. Temporary Holding facilities which hold persons longer than 12 hours shall distribute a mattress, one sheet, and one blanket. Generally speaking, IPs are entitled to certain basic rights and living conditions, including access to a bed. According to SDSD DSB P&P Section L.1 titled "Laundry Schedule," the standard issue of bedding and linen shall include: one mattress, two white towels, and two cotton/wool blankets. The Eighth Amendment to the U.S. Constitution prohibits cruel and unusual punishment, and this has been interpreted to include the provision of basic necessities, such as adequate shelter and sleeping arrangements for IPs. The evidence supported the allegation, and the act was not justified.

10. Misconduct/Procedure - SDSD failed to provide IP Schuck shower access or a (daily) shave.

Recommended Finding: Sustained
Rationale: During this investigation, and in review of jail surveillance video recordings and other evidence, it was noted that Schuck was not afforded the opportunity to shower or bathe, and he was not permitted to shave daily. Schuck was incarcerated for seven days, and within the first six days of his incarceration, he was not provided access to a shower stall. According to California Title 15 Minimum Standards, Article 13 titled "Inmate Clothing and Personal Hygiene, section 1266 titled "Showering," inmates [incarcerated persons] shall be permitted to shower/bathe upon assignment to a housing unit and at least every other day or more often if possible. Additionally, according to California Title 15 Minimum Standards, Article 13 titled "Inmate Clothing and Personal Hygiene, section 1267 titled 'Hair Care Services," inmates shall be allowed to shave daily. According to SDSD DSB P&P Section L.11 titled "Personal Hygiene," upon assignment to a housing unit an inmate will be allowed a shower and additional showers at least every 48 hours thereafter. The court holding area and its holdings cells are not considered housing units; however, the court holding area was where IPs were placed (housed) for days while they completed the quarantine process. The keyword in the law states, "once an IP is assigned to a housing unit." The term "housing unit" is open to interpretation since Schuck was housed in a holding cell for six days, and not assigned to a housing unit until his seventh day in custody. The evidence supported that Schuck was not permitted to shower/bathe or shave, and these acts were not justified.

11. Misconduct/Procedure - SDSD failed to allow IP Schuck phone access.

Recommended Finding: Not Sustained
Rationale: During this investigation, it was noted that Schuck and those IPs who were housed in the court holding cells did not have access to phones. A scene investigation revealed that the court holding cells were not equipped with phones. California Code of Regulations Title 15 Minimum Standards, Section 3282 titled "Use of Telephones by Inmates," states that facilities shall provide inmate telephones for use by inmates consistent with their assigned privilege group. A Department Information Source explained that IPs who were held in the court holding area could have access to a phone "upon request and availability." There was no documented evidence to confirm or refute that Schuck requested to use a phone during his incarceration outside of the booking area. The purpose of SDSD DSB P&P Section P.2 titled "Telephone Access," was to establish guidelines that will permit inmates to use telephones during normal operating procedures. The policy established that all inmates will be provided reasonable access to a telephone beyond those telephone calls required by law. According to the policy, telephones are to be located in areas accessible to inmates during dayroom or recreation time when they are allowed outside of their cells or dorm living units. Being that Schuck was housed in a court holding cell, he did not have access to dayroom or recreation time. Denying IPs reasonable access to communication could potentially raise concerns related to their constitutional rights and a fundamental aspect of those rights. There was insufficient evidence to either prove or disprove the allegation.

12. Misconduct/Procedure - SDSD failed to provide IP Schuck with personal care items.

Recommended Finding: Not Sustained
Rationale: It was suspected that the SDSD failed to provide Schuck with personal care items, as the SDSD usually provides IPs with personal care items when they are placed in a housing unit. As previously noted, Schuck was placed in a court holding cell for the first six days of his incarceration. According to California Title 15 Minimum Standards, Article 13 titled "Inmate Clothing and Personal Hygiene, section 1265 titled "Issue of Personal Care Items," each inmate to be held over 24 hours who is unable to supply himself/herself with toothbrush, dentifrice, soap, comb, and shaving implements, because of either indigency or the absence of an inmate canteen, shall be issued these items. According to SDSD DSB P&P Section L.11 titled "Personal Hygiene," any inmate to be held longer than 24 hours shall be supplied with those items necessary for the maintenance of adequate personal hygiene. Each inmate who is to be held beyond 24 hours will be issued a hygiene kit at the time of transfer to a housing unit. These hygiene kits will include a comb, toothbrush, toothpaste, shampoo and 2 bars of soap. Generally speaking, IPs are entitled to certain basic rights, including being provided with personal care items. A Department Information Source explained that IPs who were held in the court holding area were provided with personal care items; however, there was not documented evidence to confirm or refute this allegation. There was insufficient evidence to either prove or disprove the allegation.

13. Misconduct/Procedure - SDSD failed to provide IP Schuck access to a recreation yard/exercise.

    Recommended Finding: Sustained
    Rationale: In review of jail documents and jail surveillance video recordings of Schuck's incarceration, it was noted that Schuck was not afforded the opportunity to exercise or partake of recreation during the seven days that he was incarcerated. Denying an IP reasonable access to recreation or yard time raises concerns related to constitutional rights and standards for humane treatment. The purpose of SDSD DSB P&P Section T.11 titled "Exercise and Recreation," was to provide an opportunity for adequate exercise and recreation for all inmates. An exercise and recreation program shall be available to inmates at each facility. It shall afford the inmate an opportunity to utilize an area designed for recreation. It shall include a minimum of two (2) exercise periods, and a minimum of three (3) hours per week, per inmate. At the time of his death, Schuck had been incarcerated for approximately seven days. In those seven days, he was not provided the opportunity to exercise. The evidence supported the allegation, and the act was not justified.

14. Misconduct/Medical - Jail medical/health staff failed to conduct a second assessment on IP Schuck.

    Recommended Finding: Summary Dismissal
    Rationale: The Schuck family filed a complaint with CLERB and stated, "*Jail staff failed to follow the procedure for a clinically indicated assessment which required a second assessment within two hours of intake*." The medical screening process is a crucial step in ensuring the wellbeing of both the incoming IPs and the broader jail population, while also fulfilling legal and ethical obligations regarding healthcare in correctional facilities. Jail medical records were obtained and were reviewed; however, that information cannot be disclosed due to the Health Insurance Portability and Accountability Act (HIPPA) which protects the individual's sensitive health information. Health Services staff members are not sworn staff. The CLERB Review Board lacks jurisdiction as it cannot take any action in respect to complaint against non-sworn SDSD employees, per CLERB Rules and Regulations 4.1.2. The Review Board lacks jurisdiction.

15. Misconduct/Medical - Jail medical/health staff failed to record Schuck's medical symptoms.

    Recommended Finding: Summary Dismissal
    Rationale: The Schuck family filed a complaint with CLERB and stated, "*Intake screener failed to observe or record signs or symptoms of possible drug withdrawal or being under the influence despite Schuck's arrest for DUI."* Recording medical symptoms is an essential practice that promotes effective communication and facilitates accurate diagnosis and treatment in managing an IPs health. Jail medical records were reviewed; however, that information cannot be disclosed due to the Health Insurance Portability and Accountability Act (HIPPA) which protects the individual's sensitive health information. The "intake screen" is known as the jail's "Gatekeeper." The Gatekeeper is a non-sworn jail medical/health employee. Health Services staff members are not sworn staff. The CLERB Review Board lacks jurisdiction as it cannot take any action in respect to complaint against non-sworn SDSD employees, per CLERB Rules and Regulations 4.1.2.

16. Misconduct/Procedure – A SDPD police officer failed to document IP Schuck's pertinent medical history.

    Recommended Finding: Summary Dismissal
    Rationale: The Schuck family filed a complaint with CLERB and stated, "*Attending officer for screening failed to report possibility of recent use of alcohol or other drugs despite arrest for DUI*." According to Schuck's jail documents, he was arrested by San Diego Police Department (SDPD) police officers who also transported Schuck to jail. It was SDPD police officers who completed Schuck's jail intake documents, which included reporting known morbidities. The CLERB Review Board lacks jurisdiction as it cannot take any action in respect to complaint against non-sworn SDSD employees, per CLERB Rules and Regulations 4.1.2.

17. Misconduct/Medical – Jail medical/health staff failed to document IP Schuck's pertinent medical history.

    Recommended Finding: Summary Dismissal
    Rationale: The Schuck family filed a complaint with CLERB and stated, "*Intake screener failed to check off "hallucinating, delusional, nonsensical, unresponsive, confused, paranoid, altered mental status, or*

inappropriate conduct" during intake despite that Schuck was making "grandiose statements and "not understanding the booking process" and other nonsensical statements." Jail medical records were obtained. Those records were reviewed; however, that information cannot be disclosed due to the HIPPA which protects the individual's sensitive health information. The CLERB Review Board lacks jurisdiction as it cannot take any action in respect to complaint against non-sworn SDSD employees, per CLERB Rules and Regulations 4.1.2.

18. Misconduct/Medical – Jail medical/health staff failed to refer IP Schuck for medical or psychiatric evaluation(s).

    Recommended Finding: Summary Dismissal
    Rationale: The Schuck family filed a complaint with CLERB and stated, *"Intake screener failed to refer Schuck for medical or psychiatric evaluation prior to being accepted into the detention facility in violation of policy requiring referral where someone exhibits signs of disorganized thinking, altered mental status, or confusion."* Jail medical records were obtained. Those records were reviewed; however, that information cannot be disclosed due to HIPPA which protects the individual's sensitive health information. Health Services staff members are not sworn staff. The CLERB Review Board lacks jurisdiction as it cannot take any action in respect to complaint against non-sworn SDSD employees, per CLERB Rules and Regulations 4.1.2.

19. Misconduct/Medical – Jail medical/health staff failed to house IP Schuck in a medical housing unit.

    Recommended Finding: Summary Dismissal
    Rationale: The Schuck family filed a complaint with CLERB and stated, *"Jail staff failed to house Schuck in a medical observation bed as required despite AMA status* [Discharge against medical advice, in which a patient chooses to leave the hospital before the treating physician recommends discharge]." The decision to house an incarcerated person in a medical observation unit in made by jail medical/health staff. Health Services staff members are not sworn staff. The CLERB Review Board lacks jurisdiction as it cannot take any action in respect to complaint against non-sworn SDSD employees, per CLERB Rules and Regulations 4.1.2.

20. Misconduct/Medical – Jail medical staff failed to recognize IP Schuck's medical emergency.

    Recommended Finding: Summary Dismissal
    Rationale: The Schuck family filed a complaint with CLERB and stated, "*Jail staff failed to provide Schuck with medical care and instead brought him to court despite knowing that Schuck was exhibiting concerning symptoms such as disorganized and nonsensical thought processes, improper dress, and unexplained wounds."* Jail medical records were obtained. Those records were reviewed; however, that information cannot be disclosed due to HIPPA which protects the individual's sensitive health information. Health Services staff members are not sworn staff. The CLERB Review Board lacks jurisdiction as it cannot take any action in respect to complaint against non-sworn SDSD employees, per CLERB Rules and Regulations 4.1.2.

21. Misconduct/Medical – Jail medical/health staff failed to perform a drug test on IP Schuck.

    Recommended Finding: Summary Dismissal
    Rationale: The Schuck family filed a complaint with CLERB and stated, *"Jail staff failed to drug test Schuck upon intake."* It is not routine practice to drug test every arrestee prior to their acceptance into the jail. Nonetheless, the decision to drug test an arrestee upon their admission into jail falls under the discretion of the Medical Services Division. Health Services staff members are not sworn staff. The CLERB Review Board lacks jurisdiction as it cannot take any action in respect to complaint against non-sworn SDSD employees, per CLERB Rules and Regulations 4.1.2.

22. Misconduct/Procedure – Unidentified deputies failed to perform safety/security checks on IP Schuck.

    Recommended Finding: Unfounded
    Rationale: The Schuck family filed a complaint with CLERB and stated, "*Jail staff failed to do adequate*

wellness checks on Schuck." In review of jail documents and jail surveillance video recordings, it was noted that safety/security checks were performed in a timely manner and in compliance with SDSD P&P. The evidence shows that the alleged act did not occur.

23. Misconduct/Medical – Jail medical/health staff failed to acquire pertinent medical information prior to accepting IP Schuck into the jail.

    Recommended Finding: Summary Dismissal
    Rationale: The Schuck family filed a complaint with CLERB and stated, "*Jail staff failed to ensure that Schuck was cleared at the hospital prior to booking despite suspecting he had a baggie or balloon, possibly containing drugs, in a body cavity."* Prior an arrestee's admission into jail, they are medically assessed by jail medical/health staff. The medical screen process evaluates arrestees to determine if they are fit for jail. Jail medical/health staff make the determination. Health Services staff members are not sworn staff. The CLERB Review Board lacks jurisdiction as it cannot take any action in respect to complaint against non-sworn SDSD employees, per CLERB Rules and Regulations 4.1.2.

POLICY RECOMMENDATION:

In review of jail surveillance video camera recordings, it was noted that some camera placements were not ideal. According to SDSD DSB P&P Section I.19 titled "Security Video Systems," facilities will ensure proper placement and quality for viewing purposes and which may be of evidentiary value or administrative interest. Should adjustment be needed to the security video system, the sworn staff member will notify facility administrative staff through email and/or the facility maintenance process. The facility administrative staff will promptly notify the appropriate maintenance/facilities staff to schedule the adjustment or repair.

1. CLERB recommends that SDCJ video cameras be angled in a more opportune position to capture a greater view.

22-063/REYNOLDS (EO Parker)

1. Death Investigation/In-Custody Natural Death – On 05-25-22, Stephen Manning Reynolds, an incarcerated person at San Diego Central Jail (SDCJ), was found lying unresponsive in his single-occupant cell during a security check. Deputies and medical personnel initiated and undertook lifesaving measures. Despite those measures, Reynolds was pronounced dead in his cell.

    Recommended Finding: Action Justified
    Rationale: On 04-27-22, Stephen Reynolds was arrested by the San Diego Police Department (SDPD) for failing to register as a transient sex offender. On 05-10-22, it was determined he would be committed to the Department of Corrections (DOC) for parole violation and was subsequently awaiting transfer to DOC. On 05-25-22, deputies conducted a security check discovered Reynolds, the sole occupant of his cell, lying unresponsive in it. Deputies immediately initiated lifesaving measures. On-duty medical service providers arrived timely and assisted with resuscitative efforts. Medics arrived but, despite all resuscitative efforts, Reynolds was pronounced dead at SDCJ. The cause of death was complications of hepatocellular carcinoma and the manner of death was natural. There were no indications of trauma, suspicious activity, or neglect.

    All evidence indicated that Reynolds was properly medically screened, classified, and housed after his booking. All safety checks and counts were completely timely and within policy. Upon discovering Reynolds unconscious in his cell, sworn personnel expeditiously responded and immediately initiated lifesaving measures. There was no evidence to support an allegation of procedural violation, misconduct, or negligence on the part of Sheriff's Department sworn personnel.

    Finally, 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 Reynolds stated:

"An investigator from the San Diego County Medical Examiner's Office took custody of Mr. Reynolds' remains and conducted an independent investigation and post-mortem examination. The Medical Examiner's Office preliminarily determined the cause of death to be complications of liver cancer and the manner of death to be natural. (ME Case #2022-01749)

The CIRB initially reviewed this incident on June 15, 2022, and listed the following action item:

Item #1 – A policy recommendation that as the Detention Services Bureau (DSB) Body-Worn Camera (BWC) program comes online, deputies be required to use their BWC to document interactions during housing hard counts, safety checks and medication distribution. This requirement was implemented in DSB P&P Section I.20 – Body Worn Cameras on November 9, 2022.

The CIRB final report was received on July 10, 2023, and listed the following completed action item:

Item #1 – The CIRB recommended Detention Services Bureau policy change to section I.20 – Body Worn Cameras was implemented on November 9, 2022."

22-077/WAHLBERG (Inv. Klew)

1. Death Investigation/In-Custody Drug Related – Erica Wahlberg died while in the custody of the Sheriff's Department.

Recommended Finding: Not Sustained
Rationale: Documents received from SDSD showed that on 06-27-22, Erica Wahlberg was booked into Vista Detention Facility (VDF) after receiving a Court commitment for an outstanding warrant. Incarcerated Person (IP) Wahlberg was at VDF for approximately six hours, before being transferred to Las Colinas Detention and Reentry Facility (LCDRF). Records indicated that Wahlberg had a social history of illicit drug use and reportedly admitted to using illicit drugs prior to her arrest. Wahlberg received a medical screening while at VDF, prior to being transported to LCDRF. Wahlberg, along with three other female IPs, were placed into a temporary holding cell at LCDRF while pending intake. LCDRF documents showed that safety checks were conducted in a timely manner. While in the holding cell, a deputy noted concerns over Wahlberg's appearance and escorted her out of the cell to be searched for contraband. Additionally, the deputy requested LCDRF medical staff respond to evaluate Wahlberg. Wahlberg's physical condition continued to decline, which resulted in her being sent to a local hospital, where she was admitted. Wahlberg remained at the hospital until her death on 07-02-22. The San Diego Medical Examiner's Office conducted an autopsy of Wahlberg and the cause of death was determined to be "acute fentanyl, acetyl fentanyl and methamphetamine intoxication, with acute lobar pneumonia, bilateral as a contributing factor," and the manner of death was "accident." Toxicology testing of antemortem blood specimens taken were positive for fentanyl, acetyl fentanyl and methamphetamine. 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 Wahlberg stated, "The CIRB conducted a preliminary review of this incident on July 20, 2022, with no action items or policy recommendation at this time." In CLERB case #22-053/Ornelas, CLERB made three recommendations for 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. It should be

noted, the CIRB release for Wahlberg stated, “the Medical Examiner's Office preliminarily determined the cause of death to be ‘methamphetamine intoxication’, and the manner of death to be ‘accidental.’” However, the SDMEO report stated the cause of death was “acute fentanyl, acetyl fentanyl and methamphetamine intoxication, with acute lobar pneumonia, bilateral as a contributing factor.” The CIRB release was posted prior to the completed SDMEO report. SDSD was advised of this discrepancy. Ultimately, this investigation was unable to determine if Wahlberg obtained the drugs, which contributed to her death, while in custody or not. There was insufficient evidence to either prove or disprove misconduct on the part of SDSD personnel in this case.

USES OF FORCE RESULTING IN GREAT BODILY INJURY (1)

23-166/RAMIREZ (Inv. Klew)

1. Use of Force Resulting in Great Bodily Injury – Deputies Miguel Juarez, August Mansheim, and Dylan Trejo used force against Carlos Ramirez, which resulted in Ramirez sustaining an injury.

   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 11-24-23, deputies at the Rock Mountain Detention Facility (RMDF) were attempting to conduct a cell search, after a deputy noticed a strong smell of alcohol coming from within the cell. The cell was occupied by Carlos Ramirez and another incarcerated person. During the search of the cell, Ramirez attacked deputies and a use of force ensued. As a result of the force used, Ramirez sustained an injury. The San Diego Sheriff’s Department (SDSD) reported this incident to CLERB on 12-05-23. 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. Additionally, SDSD P&P Addendum Section F, Use of Force Guidelines, regarding striking techniques, stated, “Striking techniques are those techniques that a deputy employs using personal body weapons, i.e., fists, hands, arms, elbows, legs, head, feet and knees. Strikes are techniques in which injury may occur. There is no expectation for a deputy to receive the first strike before employing striking techniques; however, the deputy must articulate the necessity and reasonableness for striking first.” Additionally, Addendum Section F Guidelines stated, “Punching techniques may be necessary when a suspect/inmate is assaultive, or the subject exhibits signs of imminent physical attack. A fist strike to a subject’s face when reasonable and necessary is not prohibited; however, it is preferable to use an open hand (palm heel) technique to reduce the likelihood of injury to the deputy’s hand and subject's face.” Regarding the use of knee strikes, Addendum Section F stated, “Knee strikes may be used to facilitate a takedown on an actively resisting subject. The physical structure of the leg is generally stronger and may have greater impact capability than the arm, hand or fist. When using a kicking or knee strike technique, deputies should fully consider the reasonableness and necessity for doing so.” Numerous involved deputy reports, CCTV footage, and an audio recorded interview of Ramirez was available to assist CLERB’s evaluation of this incident. Based on all the evidence reviewed, the use of force was justified and the actions taken by the deputies involved were within policy. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

ROUTINE (1)

23-097/AZIZ (Inv. Bohan)

1. Misconduct/Harassment – The San Diego Sheriff Department (SDSD) followed and/or monitored the aggrieved with a drone for months.

   Recommended Finding: Unfounded
   Rationale: Laila Aziz stated in a complaint to CLERB, “For the past few months the aggrieved has been

followed by a law enforcement drone." A records request was submitted to the SDSD, which included videos, as well as dates and locations for the alleged drone activity. According to information obtained from the SDSD CLERB liaison, they had no record of surveillance involving the aggrieved during the time frame of the alleged activity and therefore had no records to provide. Furthermore, the SDSD does not patrol in the identified areas, nor do they utilize drones for surveillance. The CLERB liaison stated, "I can confirm that the provided videos, where a drone is clearly depicted, were confirmed not to be San Diego Sheriff's equipment." The evidence showed that the alleged act or conduct did not occur.

2. Criminal Conduct – The SDSD recorded a juvenile and invaded privacy at the aggrieved's home with the use of a drone.

   Recommended Finding: Unfounded
   Rationale: Aziz stated, "This Drone has monitored him at his residence and has recorded his minor child at home through the balcony. He and his minor child have been monitored by this drone unclothed. A minor being monitored by a drone in his home while he is dressing is unacceptable." See Rationale #1.

3. Misconduct/Procedure – The SDSD failed to provide policy for drone use on their website.

   Recommended Finding: Unfounded
   Rationale: Aziz stated, "We have looked online at the Sheriff's website to review the policies and procedures, for drone use and this information was not available. An Article in the Voice of San Diego, dated December 15th, 2016, the department states: The Sheriff' Department took privacy concerns into account when crafting its unmanned aerial vehicle policy, which states 'the department will not conduct random surveillance activities.'" The drone use policy, Section 6.135 Unmanned Aircraft Systems (UAS) Unit, is available on the SDSD website, refuting the allegation. It should be noted that members of the public may not know that this policy exists because the word "drone" appears nowhere in the policy or in the online SDSD policies and procedures manual. The evidence showed that the alleged act or conduct did not occur.

4. Illegal Search & Seizure – The SDSD failed to serve the aggrieved with a search warrant.

   Recommended Finding: Action Justified
   Rationale: Aziz stated, "(Aggrieved) nor his family have been served a search warrant." According to the SDSD P&P's Section 6.116 Search Warrant Service, "All Sheriff's Department employees shall execute search warrants, parole and 4th waiver searches according to established rules of law and shall not willfully violate the constitutional rights of citizens." Because the SDSD was not conducting surveillance on (aggrieved) there was no reason that a search warrant would be served. The evidence showed that the alleged act or conduct did occur and was lawful, justified and proper.

5. Misconduct/Procedure – The SDSD drone use violated the aggrieved's safety while traveling.

   Recommended Finding: Unfounded
   Rationale: Aziz stated, "The drone has also been following (aggrieved) throughout San Diego and is causing safety issues as the lights from the drone cause a hazard while traveling." See Rationale #1.

End of Report