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# County of San Diego

## CITIZENS' LAW ENFORCEMENT REVIEW BOARD

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The Citizens' Law Enforcement Review Board made the following findings in the closed session portion of its April 23, 2024, meeting held in person. Minutes of the open session portion of this meeting will be available following the Review Board's review and adoption of the minutes at its next meeting. Meeting agendas, minutes, and other information about the Review Board are available upon request or at [www.sdcounty.ca.gov/clerb](http://www.sdcounty.ca.gov/clerb).

### CLOSED SESSION

a) PUBLIC EMPLOYEE DISCIPLINE/DISMISSAL/RELEASE

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

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

### CASES FOR SUMMARY HEARING (9)

#### ALLEGATIONS, BOARD FINDINGS & RATIONALES

#### DEATH INVESTIGATIONS (2)

#### 22-056/YOUNG-VILLASENOR (Inv. Klew)

1. Death Investigation/Drug Overdose – Chaz Guy Young-Villasenor died while in the custody of the Sheriff's Department at the San Deigo Central Jail (SDCJ) on 05-05-22 .

Board Finding: Sustained

Rationale: This case was reviewed in accordance with CLERB Rules & Regulations Section 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 05-04-22, Chaz Guy Young-Villasenor, the decedent, was booked into custody at the San Diego Central Jail (SDCJ). The decedent went through the intake process, was medically cleared for housing, and was placed in a temporary holding cell. While in the temporary holding cell, a deputy noticed the decedent was unresponsive. Despite a medical response, and attempts to revive the decedent, he was pronounced dead. A bag containing a white powdery substance was found in the cell with the decedent. The substance in the bag tested positive for fentanyl and meth. On 05-06-22, the San Diego Medical Examiner's Office (SDMEO) conducted an autopsy of the decedent. The cause of death was acute fentanyl and methamphetamine intoxication, and the manner of death is accident. Per SDCSD P&P 4.23, Department Committees and Review Boards, The Critical Incident Review Board (CIRB) conducts a review of all in-custody deaths. According to the SDCSD website, the releases "are synopses of reviewed incidents and any resultant actions or policy changes intended to improve our

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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 Young-Villasenor stated, “The CIRB conducted a preliminary review of this incident on June 15, 2022. There were no policy changes or action items identified during that review.” 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 SDDS website within 10 days of the review. 2. Update CIRB Reviews on the SDDS website within five days of obtaining applicable information. And 3. Include all contributing causes of death in the CIRB Review posted on the SDDS website. The policy response is still pending from the department. Ultimately, this investigation was unable to determine how the decedent obtained the drugs which contributed to his death. However, the evidence did indicate the decedent consumed illicit drugs while he was in the custody of SDDS. The evidence supports the allegation and the act or conduct was not justified.

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

Board Finding: Sustained

Rationale: See allegation #1. Although it is undetermined how the decedent obtained the illicit drugs, the evidence indicated the decedent consumed illicit drugs while he was in the custody of SDDS. On 02-14-24, CLERB resubmitted a policy recommendation to SDDS. The synopsis of the policy recommendation is that SDDS physically search, or body scan all persons entering a SDDS-operated detention facility, to include all SDDS 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. The evidence supports the allegation and the act or conduct was not justified.

### **POLICY RECOMMENDATION:**

1. It is recommended that SDDS implement a policy which ensures temporary holding cells are searched for any contraband prior to an incarcerated person (IP) being placed there.

### **23-042/FAULKNER** (Inv. Klew)

1. Death Investigation/Drug-Related – Eddie Faulkner died while in the custody of the Sheriff’s Department at the Vista Detention Facility (VDF) on 04-17-23.

Board Finding: Sustained

Rationale: This case was reviewed in accordance with CLERB Rules & Regulations Section 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. SDDS records indicated that Eddie Faulkner was initially booked into the custody of SDDS on 11-07-22. On 04-17-23, Faulkner was housed at Vista Detention Facility. During a security check, a deputy noticed Faulkner appeared to be in medical distress. An emergency medical response was started, however, Faulkner was pronounced deceased despite aggressive attempts to revive. According to the Medical Examiner’s report, the cause of death was acute fentanyl, trazodone, and gabapentin intoxication, with hypertensive and atherosclerotic cardiovascular disease contributing, and the manner of death is accident. Included in the documents received from SDDS were several deputies reports in which other incarcerated persons, who were housed in the same module as Faulkner, were interviewed. In several of the reports, numerous incarcerated persons stated they believed that Faulkner overdosed. Additionally, several incarcerated persons made statements acknowledging there was “fentanyl” in the housing unit prior to Faulkner’s death. Per SDDS P&P Section 4.23, Department Committees and Review Boards, the Critical Incident Review Board (CIRB) conducts a review of all in-custody deaths. According to the SDDS 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 Faulkner stated, “The CIRB conducted a preliminary review of this incident on June 14, 2023, with no action items or policy recommendations at that time.” In CLERB #22-053/Ornelas, CLERB made three recommendations to CIRB reviews which included: 1. Post Critical Incident Review Board (CIRB) Reviews on the SDDS website within 10 days of the review. 2. Update CIRB Reviews on the SDDS website within five days of obtaining applicable information. And 3. Include all contributing causes of death in the CIRB Review posted on the SDDS website. The policy response is still pending from the department. Ultimately, this investigation was unable to determine how the decedent obtained the drugs which contributed to his death. However, the evidence did indicate the decedent consumed illicit drugs while Faulkner was in the custody of SDDS. The evidence supports the allegation and the act or conduct was not justified.

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

Board Finding: Sustained

Rationale: See Allegation #1. Although it is undetermined how Faulkner obtained the illicit drugs, the evidence indicated the decedent consumed illicit drugs while in the custody of SDDS. On 02-14-24, CLERB resubmitted a policy recommendation to SDDS. The synopsis of the policy recommendation is that SDDS physically search, or body scan all persons entering a SDDS-operated detention facility, to include all SDDS 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. The evidence supports the allegation and the act or conduct was not justified.

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## **USES OF FORCE RESULTING IN GREAT BODILY INJURY (4)**

### **23-051/PHOENIX** (Inv. Wigfall)

1. Use of Force Resulting in Great Bodily Injury – Deputies Mark Bautista and Rudy Peraza utilized force to gain compliance from Incarcerated Person (IP) Brandon Phoenix on 04-07-23.

Board Finding: Action Justified

Rationale: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. SDDS documentation showed that on 12-16-22, Phoenix was arrested by the Escondido Police Department and booked into the Vista Detention Facility. According to SDDS documentation, on 04-07-23, deputies observed Phoenix’s arm extended from the handcuffing port of his cell. Deputies spoke with him for several minutes as they attempted to gain his cooperation to place his hands back inside his cell, but he did not comply. Deputy Peraza held the port flap open while Deputy Bautista attempted to move Phoenix’s right arm from the port. During this interaction, deputies stated Phoenix delivered a closed fist hand strike to Deputy Bautista’s abdominal area. Deputy Peraza reported he shut the flap as Phoenix pulled his arm back in, but Phoenix’s fingers got caught in the port as he attempted to close it. 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 reasonably perceived level of actual or threatened resistance. In addition, policy states the level of force applied must reflect the totality of circumstances surrounding the situation at hand. Phoenix was classified and housed in Administrative Separation, where the dayroom is occupied by one IP at a time. It was unsafe to have any handcuffing ports open while the dayroom is in use. Phoenix was noncompliant with staff instructions and delayed jail operations. Deputies Bautista and Peraza provided confidential statements during CLERB’s investigation that supported the recommended finding. The evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

2. Excessive Force – Deputies 1 and 2 injured IP Phoenix’s finger.

Board Finding: Action Justified

Rationale: Complainant Phoenix stated he had his hands sticking out of the handcuffing port when arguing with deputies about different restrictions he had experienced when deputies “slammed” the food flap on his finger. He said he experienced a lot of pain and suffered a broken finger. See Rationale #1. The evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

3. Misconduct/Procedure – Deputies 1 and 2 did not offer Phoenix medical attention.

Board Finding: Unfounded

Rationale: Complainant Phoenix reported that following the use of force, “nobody offered him medical attention the day of the incident” and he was denied medical attention for one week. Deputy 1 reported he offered Phoenix medical services after the incident, but he refused and cursed at deputies. SDSO documentation confirmed that medical staff responded and attempted to evaluate Phoenix through his cell window, but he covered the window with toilet paper and refused to be seen. Phoenix later requested to see medical and was evaluated through his cell door but refused care. On 04-08-23, Phoenix was escorted to medical where he received treatment and he was subsequently transported to a hospital for further care. Addendum F, Use of Force Guidelines states “Whenever a subject requires or reasonably requests medical attention after a use of force incident, a deputy shall provide medical attention, request medical aid, and/or transport them to a medical facility as soon as it is safe and practical.” The evidence shows that the alleged act or conduct did not occur.

4. Misconduct/Medical – SDSO medical staff denied IP Phoenix medical attention.

Board Finding: Summary Dismissal

Rationale: Complainant Phoenix reported that following the use of force, “nobody offered him medical attention the day of the incident” and he was denied medical attention for one week. He stated he received, “No pain relief, not even Tylenol.” See Rationale #3. SDSO DSB P&P states that any incarcerated person in the custody of the San Diego Sheriff shall have quality and timely access to care for their medical needs. SDSO records showed Phoenix initially refused medical attention but he was subsequently evaluated and treated by medical personnel. Per CLERB Rules and Regulations, CLERB has no authority over medical staff who are non-sworn personnel and their decisions. The Review Board lacks jurisdiction.

5. Misconduct/Procedure – Unidentified deputies required IP Phoenix to wear leg and waist chains while in dayroom.

Board Finding: Action Justified

Rationale: Complainant Phoenix reported he must wear leg/waist chains during his dayroom time. SDSO DSB P&P, J.9 Dayroom Waist and Leg Chains states incarcerated persons whose actions have demonstrated a propensity for violence and or the destruction of property, to include other justifiable factors, may be recommended to wear waist and leg chains during their designated dayroom time. SDSO documentation showed that deputies determined Phoenix should be placed on Dayroom Waist and Leg Chains (DRC) status due to his extensive assaultive history. DRC restriction review took place in accordance with policy. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

6. Misconduct/Procedure – Unidentified deputies denied IP Phoenix a shower while he was housed in Administrative Separation (Ad-Sep).

Board Finding: Unfounded

Rationale: Complainant Phoenix claimed he had not received a shower for “weeks.” He stated he attempted to speak to deputies about his hygiene issues, but it was ineffective. He then asked to speak with the sergeant but was “harshly denied.” He later stated deputies “had him in greens and shackled him while taking a shower,” so he refused his showers because he felt restricted wearing chains. See Rationale #5. SDSO documentation showed that deputies offered Phoenix a shower and access to dayroom, but he refused several times. In addition, CLERB inquired about the shower process when an IP is assigned to DRC, and they are in fact mandated to wear leg/waist chains while they shower in the dayroom. These leg/waist chains have an extended reach to enable IPs the ability to shower. Evidence showed Phoenix was

offered showers, but he refused due to his DRC restriction. The evidence shows that the alleged act or conduct did not occur.

7. Misconduct/Procedure – The SDSD sent IP Phoenix to a “state mental hospital.”

Board Finding: Action Justified

Rationale: Complainant Phoenix reported that he was sent to a state mental hospital so the SDSD would “save face” and would not get in trouble, face suspension or demotion for “extreme use of force violating the 8th Amendment of the U.S. Constitution; Cruel and Unusual Punishment.” The San Diego Superior Court makes the determination where an IP will serve their sentence. SDSD documentation showed that the Superior Court committed Phoenix to State Hospital, Pursuant to Penal Code 1370. The Department of State Hospitals (DSH) manages the California state hospital system, which provides mental health services to patients admitted into DSH facilities. Phoenix was transported to Metropolitan State Hospital on 08-08-23 but returned to the Vista Detention facility on 03-19-24. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

### **23-057/HERSHMAN** (Inv. Wigfall)

1. Use of Force Resulting in Great Bodily Injury – Deputies Salvador Arreola, Adrien Carrillo, Christian Davis, Richard Madden, Gustavo Martinez, Kevin Moore and Daniel Xochihua used force towards Ryan Hershman while being booked at the San Diego Central Jail on 08-26-21.

Board Finding: Action Justified

Rationale: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 08-26-21, Ryan Hershman was arrested by the San Diego Sheriff’s Department and booked into San Diego Central Jail. Hershman was placed into a holding cell, when he reportedly became “agitated” and cursed at deputies. Deputies attempted to de-escalate and escort him to another cell, but he did not comply and resisted. Additional deputies responded and Hershman became assaultive towards deputies who subsequently delivered hand and leg strikes and deployed a Conductive Energy Device (CED). Hershman was subdued and then evaluated by jail medical staff for his injuries. SDSD P&P states employees shall not use more force in any situation than is reasonably necessary under the circumstances. The evidence showed that deputies used a reasonable amount of force, given the totality of circumstances and the alleged act or conduct did occur but was lawful, justified and proper.

2. Use of Force Resulting in Great Bodily Injury – Deputy Andres Garcia used force towards Ryan Hershman while being booked at the San Diego Central Jail on 08-26-21.

Board Finding: Summary Dismissal

Rationale: See Rationale #1. Per, SDSD Division of Inspectional Services, Deputy Garcia is no longer employed with the Sheriff’s Department. Per CLERB Rules and Regulations, a summary dismissal may be appropriate when the subject officer is no longer employed by the Sheriff Department. The review board lacks jurisdiction.

### **23-106/EBERT** (Inv. Aldridge)

1. Use of Force Resulting in Great Bodily Injury – Deputies Robert Brauer, Austin Druda, Velia Haggerty, Evan Maldonado, and James Manibusan used force to subdue and arrest Brent Aaron Ebert on 07-01-23.

Board Finding: Action Justified

Rationale: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 07-01-23, Brent Aaron Ebert was found to be in possession of a stolen vehicle. When deputies attempted to perform a traffic stop on Ebert’s vehicle, he failed to yield which resulted in a vehicle pursuit. At the end of the pursuit, Ebert exited the vehicle and fled on foot, continuing to disobey the deputies’ commands to stop running. Deputies eventually apprehended

Ebert, who resisted, which resulted in a use of force. Ebert was subdued, arrested, and transported to the hospital for injuries he sustained. The use of force observed in the deputies' Body Worn Camera (BWC) recordings, coincided with what was documented in their written reports. In review of all evidence for this case, which included numerous BWC recordings, photographs, reports, and statements, the force used against Ebert was determined to be necessary, appropriate, effective, and reasonable given the circumstance and for deputies to gain compliance. During the incident, Ebert exhibited active and assault resistance toward deputies. In response, the deputies executed physical force control techniques. The actions executed by the deputies were in accordance with SDSD Policies and Procedures. There was no evidence to support an allegation of procedural violation, misconduct, or negligence on the part of Sheriff's Department sworn personnel.

2. Criminal Conduct – SDSD Deputies “broke all laws” pursuing Ebert.

Board Finding: Unfounded

Rationale: On 09-14-23, CLERB received a signed complaint from Ebert regarding the incident that led to his arrest. See Rationale #1. Ebert alleged that deputies “broke all laws” when they were in pursuit of him. According to SDSD documents related to the pursuit, a Sheriff's dispatcher logged in the deputies' traffic and activities as they pursued Ebert. As noted in SDSD policy, deputies are generally permitted to initiate a high-speed chase or pursuit when there is an imminent threat to public safety or if a serious crime has been committed. The protocols and procedures that govern a deputies' involvement in a pursuit are dictated by law, SDSD P&P, as well as the SDSD Law Enforcement Services Bureau Field Operations Manual. Additionally, these policies generally dictate when a pursuit should be initiated, continued, or terminated. The SDSD requires deputies to weigh the risks of pursuit against the potential dangers of allowing a suspect to escape. This involves assessing factors such as the severity of the crime, road conditions, weather, and traffic. In the deputies' reports, they articulated that Ebert fled through city streets before merging onto a highway where he proceeded at speeds of 60-80 miles per hour and executed dangerous driving techniques, including running through red lights, in his attempt to evade deputies. Ebert merged into opposing lanes of traffic and continued evading deputies, at which point the deputies discontinued their pursuit. According to SDSD P&P, a vehicle pursuit exposes the public, deputies, and fleeing violators to the potential risk of death, serious injury, or damage to personal property. When engaged in a pursuit, deputies should weigh the seriousness of the violator's suspected crime against the potential for death or injury if the pursuit is continued. Frequently, discontinuance of a pursuit in the interest of public safety is most appropriate. While engaged in a pursuit, deputies are generally expected to follow traffic laws to the extent possible, considering the circumstances. In review of the deputies who engaged in the vehicle pursuit of Ebert, the deputies obeyed the rules of the road. There was no evidence to support an allegation of procedural violation, misconduct, or negligence on the part of Sheriff's Department sworn personnel. The evidence showed that the alleged act or conduct did not occur.

3. Excessive Force – Deputy 4 “punched” Ebert.

Board Finding: Action Justified

Rationale: In Ebert's written complaint to CLERB, he reported that Deputy 4 executed excessive force during his arrest when Deputy 4 “punched” him. See Rationale #1. Ebert was observed to fight with Deputy 2. As Deputy 4 approached the altercation, he witnessed Ebert attempting to grab Deputy 2's duty gear on his vest. In response, Deputy 4 used his right forearm and elbow to strike Ebert in the face. Deputy 4 reported that had he not used force, he believed Ebert would have continued to attack Deputy 2 and/or him. Deputy 4 felt that the force used was effective as it freed Deputy 2 from being grappled by Ebert and allowed the responding deputies to safely detain Ebert, preventing him from attacking others. The force executed by Deputy 4 to subdue and arrest Ebert was captured in the involved deputies body worn camera recordings, as well as noted in their reports. The force used was noted to be minimal, necessary, and objectively reasonable to effect the arrest and overcome resistance. The evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

4. Excessive Force – Deputy 2 “punched” Ebert.

Board Finding: Action Justified

Rationale: In Ebert's written complaint to CLERB, he reported that Deputy 4 executed excessive force during his arrest when Deputy 4 "punched" him. Ebert named Deputy 4 in his complaint; however, in review of the deputies' reports and body worn cameras, it was noted that both Deputy 2 and Deputy 4 used techniques that resulted in Ebert getting struck in the face. See Rationale #1. Deputy 2 articulated that based off his training and experience, fleeing felons and vehicle thieves are known to carry firearms or deadly weapons, and will use physical force against law enforcement to avoid being arrested. During Deputy 2's foot pursuit and use of force with Ebert, Ebert used his feet to kick Deputy 2 in his attempt to prevent Deputy 2 from gaining control of him. Deputy 2 reported that he felt Ebert grab onto his duty belt and gear, on his right side where Deputy 2 kept his holstered firearm. To prevent Ebert from gaining control of him, or any of his issued gear, to include his gun, Deputy 2 used a closed fist to punch Ebert in the face four to five times until he felt Ebert release his hand from his duty belt. Deputy 2 reported that the force used was necessary to prevent Ebert from escape, self-defense, and to prevent him from possibly running into an occupied residence. The force used was effective and ultimately resulted in safely detaining Ebert in handcuffs and preventing further injury to the deputies or other bystanders. The force used was noted to be minimal, necessary, and objectively reasonable to effect the arrest and overcome resistance. The evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

5. Misconduct/Truthfulness – Deputy 4's statements were "all over the board."

Board Finding: Unfounded

Rationale: In his written complaint to CLERB, Ebert reported that Deputy 4 was untruthful. Ebert reported, "*I never reached for him as he claims, nor was I arrested for resisting or assault on an officer. His statements are all over the board.*" As noted above, Ebert's assaultive behavior and active resistance was captured in the multiple deputies BWC recordings. According to Ebert's jail booking documents, he was arrested for violation of obstructing/resisting a peace officer, resulting in injury, evading, and numerous other charges. Ebert was transported to jail and attended court for his offenses. He was found guilty, convicted on 09-25-23 and sentenced to a four-year term in state custody with the California Department of Corrections and Rehabilitation.

**23-165/ROBERTS** (Inv. Klew)

1. Use of Force Resulting in Great Bodily Injury – Deputy Daniel Jaimes used force against William Roberts which resulted in Roberts sustaining an injury.

Board Finding: Action Justified.

Rationale: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 11-18-23, San Diego Sheriff's Department (SDSD) Deputy Jaimes observed William Roberts consuming an alcoholic beverage in a public place. Roberts appeared to be under the influence of alcohol. Roberts resisted Deputy Jaimes' attempt to detain him resulting in a use of force incident. Roberts sustained an injury as a result of the force used. SDSD Policy 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." SDSD P&P Addendum Section F, 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. Unorthodox tactics such as head butting may be used to escape grappling holds when other personal body weapons are otherwise trapped by the attacker." Additionally, Addendum Section F stated "Factors that will affect a deputy's choice of force options include but are not limited to: A subject's age and physical stature, demonstration of pugilistic intent, physical condition and/or injuries to the subject, the deputy's knowledge of other factors representing imminent danger, the number of subjects and/or deputies, the subject's state of sobriety, subject's proximity to weapons, availability of options for deputies, pregnant, physical, mental, or developmental disabilities." A

review of the above P&P, Deputy Jaimes' report, and available video evidence of this incident showed the use of force by Deputy Jaimes was justified. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

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**PRIORITY (0)**

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**ROUTINE (3)**

**23-040/CHAMBERS** (Inv. Wigfall)

1. Misconduct/Discourtesy – Deputy 1 used foul language towards Parrish Chambers.

Board Finding: Summary Dismissal

Rationale: Complainant Chambers stated that on 02-07-23 deputies used foul language towards him. He reported he was escorted by deputies back to his module when he grabbed a blanket from a laundry bin. He reported that a deputy told him, "What are you doing stupid motherfucker!" Chambers stated he replied, "What it looks like!" (dropped the blanket back into the laundry bin) and the deputy approached him and responded, "What Bitch!" Chambers also reported the deputy told him, "Put your face to the ground motherfucker." Deputy 1 separated from the Sheriff's Department on 09-05-23. Per CLERB Rules and Regulations, a summary dismissal may be appropriate when the subject officer is no longer employed by the Sheriff's Department. The review board lacks jurisdiction.

2. Misconduct/Discourtesy – Deputy 3 used foul language towards Chambers.

Board Finding: Not Sustained

Rationale: Complainant Chambers stated on 02-07-23 deputies used foul language towards him. SDSD P&P states that employes shall be tactful in the performance of their duties, shall control their tempers, exercise patience and discretion even in the face of extreme provocation. Coarse, profane, or violent language is generally prohibited. Deputy 3 provided a confidential statement that was considered in the outcome of the recommended finding. Deputy reports stated that Chambers used foul language towards the deputies. Jail surveillance video was reviewed but absent an audio recording, there was insufficient information to either prove or disprove the allegation.

3. Excessive Force – Deputy 1 used force towards Chambers.

Board Finding: Summary Dismissal

Rationale: Complainant Chambers stated deputies used "excessive force" towards him on 02-07-23. Deputy 1 separated from the Sheriff's Department on 09-05-23. Per CLERB Rules and Regulations, a summary dismissal may be appropriate when the subject officer is no longer employed by the Sheriff's Department. The review board lacks jurisdiction.

4. Excessive Force – Deputy 3 used force towards Chambers.

Board Finding: Not Sustained

Rationale: Complainant Chambers stated deputies used "excessive force" towards him on 02-07-23. Chambers stated deputies approached him, told him to turn around and place his hands on the wall, when deputies "grabbed" him and "punched him from every angle." SDSD P&P states employees shall not use more force in any situation than is reasonably necessary under the circumstances. According to Addendum F, Use of Force Guidelines the use of hands-on control (hard hands control, powerful hand/leg strikes, etc.) are techniques used to control more assaultive individuals. Chambers submitted an Internal Affairs (IA) complaint and IA responded and reported that "deputies utilized appropriate force to gain control" and there was no indication of excessive force or misconduct. Deputy reports stated Chambers did not comply with their commands and as deputies attempted to handcuff him, Chambers "quickly pulled away" and "raised both his hands in a fighting stance." Deputy 1 stated he attempted to take Chambers down to prevent other



IPs from attacking the deputies. When Chambers reportedly pulled away, the deputies reported they delivered two closed fist hand strikes to his face/head area, then pulled Chambers to the ground. Deputy reports stated Chambers attempted to push himself off the ground, so Deputy 1 delivered one knee strike to Chambers abdominal area. The force ultimately prevented Chambers from standing up and he eventually complied. Deputy 3 also provided a confidential statement that was considered for the recommended finding. Jail surveillance video was reviewed, but given the poor video quality, there was insufficient evidence to prove or disprove the allegation.

5. Excessive Force – Deputy 1 picked Chambers up by his ponytail and legs.

Board Finding: Summary Dismissal

Rationale: Complainant Chambers alleged deputies utilized “excessive force” and picked him up by his ponytail and legs. Deputy 1 separated from the Sheriff’s Department on 09-05-23. Per CLERB Rules and Regulations, a summary dismissal may be appropriate when the subject officer is no longer employed by the Sheriff’s Department. The review board lacks jurisdiction.

6. Excessive Force – Deputy 3 picked Chambers up by his ponytail and legs.

Board Finding: Not Sustained

Rationale: Complainant Chambers alleged deputies utilized “excessive force” and picked him up by his ponytail and legs. See Rationale #4. SDS D P&P states employees shall not use more force in any situation than is reasonably necessary under the circumstances. Deputy 3 provided a confidential statement that was considered for the recommended finding. Jail surveillance video was reviewed, but given the poor video quality, there was insufficient evidence to prove or disprove the allegation.

7. Misconduct Medical – Medical staff were unconcerned about Chambers injuries.

Board Finding: Summary Dismissal

Rationale: Complainant Chambers reported that after the use of force incident, SDS D medical staff showed a “lack of concern” for his injuries. He claimed they did not provide him with the “proper care and attention.” Chambers reported he was seen by a nurse for a “few minutes” then placed in “lock up.” SDS D documentation showed that Chambers was evaluated by medical staff. In addition, 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. SDS D DSB P&P states that any incarcerated person in the custody of the San Diego Sheriff shall have quality and timely access to care for their medical needs. Medical staff are non-sworn and CLERB lacks jurisdiction.

8. Misconduct/Procedure – Deputies 2, 6 and/or 7 did not respond to Chambers’ grievance(s).

Board Finding: Not Sustained

Rationale: Complainant Chambers reported he was deprived due process with the grievance procedure when he submitted grievances on 02-11-23, 02-19-23 and 03-03-23. SDS D documentation showed that Deputy 2 was scheduled as the North Sergeant and Deputy 7 was scheduled as the Central/Processing Sergeant and that a grievance dated 02-11-23 was signed as received by Deputy 6. DSB P&P Section N.1 Grievance Procedures states that the incarcerated person grievance procedure is designed to address incarcerated person complaints related to any aspect of condition of confinement that directly and personally affects the incarcerated person. Policy also states that the deputy who receives and signs for a grievance will be responsible for entering it into JIMS. Evidence showed this grievance was not documented in JIMS, therefore it did not generate a Grievance Report. Grievance #3 dated 03-03-23, generated a Grievance Report stating Chambers was advised to proceed with a complaint to Internal Affairs (IA). The IA complaint response stated that all grievances were handled appropriately and did not rise to the level of employee misconduct. Deputies 2, 6 and 7 provided confidential statements that were considered in arriving at the recommended finding. There was insufficient evidence to prove or disprove the allegation.

9. Misconduct/Procedure – Deputy 5 did not respond to Chambers’ grievance.

Board Finding: Sustained

Rationale: Complainant Chambers reported he was deprived due process with the grievance procedure when he submitted grievances on 02-11-23, 02-19-23 and 03-03-23. Evidence showed the grievance dated 02-19-23 was signed as received by Deputy 5. Evidence showed this grievance was not documented in JIMS, therefore it did not generate a Grievance Report. DSB P&P Section N.1 Grievance Procedures states that the incarcerated person grievance procedure is designed to address incarcerated person complaints related to any aspect of condition of confinement that directly and personally affects the incarcerated person. Policy also states that the deputy who receives and signs for a grievance will be responsible for entering it into JIMS. Furthermore, a Departmental Information Source clarified that the only reason for a grievance not to be entered into JIMS would be a medical and/or anonymous grievance or a grievance that is determined to be a request. Deputy 5 provided a confidential statement that was considered in arriving at the recommended finding. The evidence showed there was a policy violation regarding the required JIMS documentation. The evidence supports the allegation, and the act or conduct was not justified.

10. Misconduct/Procedure – Deputy 4 did not respond to Chambers' grievance.

Board Finding: Unfounded

Rationale: Complainant Chambers reported he was deprived due process with the grievance procedure when he submitted grievances on 02-11-23, 02-19-23 and 03-03-23. Evidence showed the grievance dated 03-03-23 was signed and received by Deputy 4. SDSO documentation showed that Deputy 4 entered the grievance into JIMS, which generated a Grievance Report. Deputy 4 responded to this grievance in accordance with policy and procedure. The evidence shows that the alleged act or conduct did not occur.

**23-079/KUYKENDALL** (Inv. Chiesa)

1. Misconduct/Medical – Jail medical staff “refused” to address Kuykendall’s medical needs.

Board Finding: Summary Dismissal

Rationale: The complainant, Kuykendall, stated he has “been experiencing a lot of deliberate indifference concerning his medical health care”. Per DSB P&P M.15, entitled “Sick Call”, Inmates shall have access to appropriate medical and mental health services on a daily basis. CLERB lacks jurisdiction to investigate the complaint, per CLERB Rules and Regulations 4.1 titled, Citizen Complaints: Authority, which states, CLERB shall have authority to receive, review, investigate, and report on complaints filed against peace officers or custodial officers employed by the County in the Sheriff’s Department or the Probation Department. CLERB has no jurisdiction over medical personnel. The review board lacks jurisdiction.

2. Misconduct/Procedure – Unidentified deputies confiscated Kuykendall’s wheelchair.

Board Finding: Not Sustained

Rationale: Kuykendall stated, “they moved me from ADA compliance general population, taken my wheelchair and assaulted me.” In review of the numerous Incident Reports written regarding Kuykendall, many of the “information only” reports documented that Kuykendall was observed without the need of a cane or wheelchair. Sworn and medical staff notated Kuykendall was able to ambulate without assistive devices throughout his incarceration. At the time of his arrest, Kuykendall was not in possession of a cane nor a wheelchair. Nonetheless, Kuykendall demanded a wheelchair while in custody due to a medical condition. Jail medical staff issued Kuykendall a walking cane for short distances, and subsequently a wheelchair for longer distances. CLERB has no jurisdiction over medical personnel and was unable to further investigate wheelchair and mobility requests and approvals. SDSO records showed Kuykendall was moved from George Bailey Detention Facility (GBDF) to San Diego Central Jail (SDCJ) on 04-25-23. According to Division of Inspectional Services, Sergeant Bracy, there was limited video footage available on 04-25-23 due to the length of time since the incident. Sergeant Bracy provided video footage which may be Kuykendall walking down the out-courts hallway. The assumption was based on Kuykendall’s size and cane, however due to a COVID facemask the department was unable to positively identify. The video showed a large man briskly walking with a cane. In one video, a wheelchair can be seen behind a possible Kuykendall. The

wheelchair appeared to have a fully loaded plastic bag in it. The department was also unable to verify who transferred Kuykendall due to entry times in JIMS varying from actual time moved and poor video quality. Jail Information Management System entries are manually inputted and not real time updates. SDCJ Medical Records noted on 05-01-23 when Kuykendall was transferred to SDCJ his wheelchair was taken away. SDCJ medical notes indicated on 05-05-23 a wheelchair was provided per provider order. Due to the length of time from the incident, lack of video evidence, and inability to positively identify deputies and Kuykendall, there was insufficient evidence to determine if this incident occurred. Furthermore, it was unknown if Kuykendall was offered a wheelchair for transfer but refused. SDCJ records indicated Kuykendall was frequently seen not requiring assistance devices and his dependence on mobility devices was inconsistent and intermittent. There was insufficient evidence to either prove or disprove the allegation.

3. Misconduct/Procedure- SDCJ failed to retain routine video monitoring videos.

Board Finding: Sustained

Rationale: SDCJ DSB P&P B.37 titled, "Record Retention and Destruction", states "records shall be retained for the length of time required to satisfy legal, liability, and audit requirements and shall be disposed of in compliance with legal procedures". Through the course of investigation it was discovered routine video monitoring was not retained for the minimum period of one year. CA Code 34090.6 establishes guidelines for the destruction of routine video monitoring. Per the code, routine video monitoring includes jail observation and monitoring systems and allows the destruction of the recordings one year. In an effort to align with California code, it is recommended SDCJ develop policy and procedure to retain routine jail video for a period greater than one year. It is recommended videos are retained for two years for CLERB to investigate complaints that may come in towards the end of CLERB filing time periods. The evidence supports the allegation and the act or conduct was not justified.

4. Misconduct/Procedure – Unidentified deputies "removed" Kuykendall from ADA compliant housing.

Board Finding: Action Justified

Rationale: Kuykendall stated he was moved from ADA compliant housing, and his wheelchair was taken due to grievances he wrote. SDCJ DSB P&P M.39 titled "Disabled Incarcerated Persons", states "The department recognizes disabled incarcerated persons are entitled to the same rights, privileges, and services as other incarcerated persons of the same classification level per the Americans with Disabilities Act (ADA)". SDCJ records showed lower bunk and tier medical instructions for Kuykendall with a start date of 07-06-22. SDCJ records showed Kuykendall complained of the same issue in January 2023 and December 2022. A Sergeant provided a thorough response and unfounded the claims. The Sergeant's response outlined the cell placement and ADA compliance. The evidence showed Kuykendall was designated a wheelchair for long distance usage. SDCJ records also produced multiple Incident reports that documented Kuykendall was observed not needing medical assistance. The incident reports indicated Kuykendall was observed "dancing", "working out", and moving around dayroom without assistance. The evidence suggested Kuykendall may be attempting to manipulate jail housing. An incident report showed on 07-25-23 Kuykendall arrived in a new housing module and saw another Incarcerated Person (IP) whom he knew. According to the report, Kuykendall volunteered to be housed in non-compliant ADA cell with that IP. After the deputy spoke with classification, classification advised Kuykendall needed to be placed in ADA compliant housing and was moved back. SDCJ records showed Kuykendall was placed in non-ADA compliant housing for potentially less than 2 hours. Due to JIMS input time variation the exact time is unknown. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

5. Misconduct/Retaliation – Unidentified deputies "assaulted" and "dragged" Kuykendall.

Board Finding: Unfounded

Rationale: Kuykendall stated, "they moved me from ADA compliance general population, taken my wheelchair and assaulted me." Furthermore, Kuykendall stated deputies "dragged" him at George Bailey Detention Facility in February or March 2023. There was no indication deputies "assaulted" Kuykendall. Kuykendall's Inmate History Report showed no documented uses of force or incidents that would indicate injury in February or March 2023. SDCJ medical records indicated on 03-28-23 was seen in a follow up due

to a fall from his top bunk on 01-20-23. The medical notes indicated Kuykendall injured his neck, shoulder, back knees, head ankles, and had a concussion. It was also noted in the medical notes that he was “rough handled” during transfer. There was no other mention or documentation of any sort indicating a use of force. The evidence showed the alleged act or conduct did not occur.

6. Misconduct/Retaliation – Unidentified deputies “isolated” Kuykendall in a single cell.

Board Finding: Unfounded

Rationale: Kuykendall stated, “The Sheriff Deputies, Sgt, Lt, Captains have been retaliating, discriminating and threatening me. Now they’ve isolated me off in a single man cell, where I can’t video visit with my family like other inmates. I’m unable to interact or socialize with other inmates.” The evidence showed Kuykendall was in protective custody, in an ADA compliant cell, and was not in disciplinary segregation or administrative separation. The evidence showed the alleged act or conduct did not occur.

7. Misconduct/Retaliation – SDSO restricted Kuykendall’s video visits.

Board Finding: Action Justified

Rationale: Kuykendall stated he is not allowed video videos with family like other inmates. Title 15 Guidelines states, “Visits may not be cancelled unless a legitimate operational or safety and security concern exists. All cancelled visits must be documented. The facility manager or designee shall regularly review cancelled visits and document such review.” SDSO DSB P&P P.9 titled, “Social visiting”, establishes guidelines for permitting Incarcerated Persons social visits. Per the policy, social visits and video visitations are a privilege, and as such, (at the discretion of the Watch Commander) may be suspended as part of a disciplinary action. Furthermore, the policy states the Watch Commander may temporarily suspend facility visits in the event of any emergency that threatens the safety and security of the facility. The policy also states, “The Watch Commander will resolve questions regarding the eligibility for either the Incarcerated Person or visitor.” SDSO records showed Kuykendall submitted a grievance regarding video visits once he was transferred to the medical observation unit. According to the Grievance response, the video visit terminal was experiencing technical difficulties at the time. By the time of the grievance response dated 07-03-23, the video terminal was corrected, and website updated to allow video visits. There was no record of visitation suspension for Kuykendall. The evidence showed it was a maintenance issue that briefly prevented Kuykendall from video visits, and the issue was promptly reconciled. There was no evidence that showed deputies intentionally prevented Kuykendall from his social visits. According to SDSO documentation, the evidence suggested Kuykendall filed his original grievance complaint regarding the video issue on 06-18-23, an additional appeal on 06-27-23, and the issue was reconciled on/or before 07-03-23. The evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

8. Misconduct/Procedure – Unidentified deputies failed to respond to Kuykendall’s grievance.

Board Finding: Action Justified

Rationale: Kuykendall stated his grievances were unanswered. According to SDSO DSB P&P N.1 titled “Grievance Procedure”, states Incarcerated Persons may use the grievance procedure for complaints related to any aspect of condition of confinement that directly and personally affects the Incarcerated Person grievance. The policy states, this includes food, clothing, and bedding. SDSO records showed Kuykendall was a chronic complainer who submitted multiple grievances to include but not limited to: clothing sizes, loss of commissary items, unanswered grievances, spoiled food, air conditioning, cell condition, video visits, search procedures, maintenance issues, bunk size, medical care, dayroom schedule, rec yard use, unprofessional staff, discrimination, housing placement, and disciplinary action. SDSO records showed all grievances were issued a response with one exception in which the grievance was a staff complaint. SDSO records showed one grievance report dated 07-08-23 in which Kuykendall claimed he did not receive an answer to a grievance he submitted to a Sergeant. The report indicated the grievance submitted to the Sergeant was a complaint against staff and the grievance was forwarded to the deputy’s immediate supervisor. Per policy complaints against staff are not grievances and will be handled as a complaint against staff. The immediate supervisor of the employee named in the complaint determines if a formal investigation

is warranted, and if so, the supervisor will forward to Internal Affairs. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

### **POLICY RECOMMENDATION:**

1. It is recommended the San Diego Sheriff's Department (SDSD) develop policy and procedure to retain routine jail video for at least one year. CLERB strongly recommends for the retention beyond one year for CLERB to investigate complaints that may come in towards the end of CLERB's filing time periods.

### **23-116/JOHNSON** (Inv. Chiesa)

1. Misconduct/Procedure – Deputy 1 failed to escort Incarcerated Person (IP) Sedric Johnson for medical services.

#### Board Finding: Action Justified

Rationale: According to the complainant, Sedric Johnson, on 09-22-23 Deputy 1 told Johnson he would come back to take Johnson to Medical but never returned. SDSD medical records indicated Johnson refused to speak to medical unless he came to the clinic but was unable to be seen at the clinic due to a lockdown. There was no evidence that indicated Johnson required immediate medical attention and/or requested to be escorted to medical for an urgent medical need. Medical notes indicated sick call was rescheduled for 09-23-23 but Johnson was subsequently transferred from San Diego Central Jail (SDCJ) to George Bailey Detention Facility (GBDF). Johnson was then seen on 09-25-23 and further medical requests were made. CLERB reviewed protected health information during the course of investigation that was considered in arriving at the recommended finding. Protected health information is protected by HIPPA and CMIA are deemed confidential by law and cannot be publicly disclosed. CLERB Rules and Regulations 4.1 titled, Citizen Complaints: Authority, which states, CLERB shall have authority to receive, review, investigate, and report on complaints filed against peace officers or custodial officers employed by the County in the Sheriff's Department or the Probation Department. CLERB has no jurisdiction over medical personnel and was unable to further investigate decisions made by medical personnel. Based on the evidence, the evidence showed the alleged act or conduct was lawful, justified, and proper.

2. Misconduct/Procedure – Unidentified deputies housed Johnson in a cell with raw sewage and chemicals.

#### Board Finding: Not Sustained

Rationale: Johnson alleged the holding cell he was placed in prior to his housing assignment at GBDF "had feces, urine, and some chemical agent in the toilet. No toilet paper." Johnson stated due to the smell he got a bad headache, shortness of breath, and rapid heartrate. SDSD records showed Johnson was transferred from SDCJ to GBDF on 09-23-23 at 1:26PM. According to the Inmate History Summary Report Johnson was temporarily placed in Facility 3, area X for approximately 10 minutes. However, due to JIMS entries not being updated in real time, the exact amount of time was unknown. 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, "Housing deputies are responsible for maintaining the cleanliness of the following areas: corridors, walkways, **holding cells, (emphasis added)** multipurpose room, medical exam room, medical holding cell, hair care, recreation yard, janitor closet, and storage areas." Due to the length of time since the incident, and lack of available evidence, there was insufficient evidence to determine the condition of Johnson's temporary holding cell. There was insufficient evidence to either prove or disprove the allegation.

3. Excessive Force – Deputy 2 "slammed" Johnson's hand in the tray slot.

#### Board Finding: Not Sustained

Rationale: Johnson alleged on 09-24-23 at GBDF at 5:10AM Deputy 2 slammed Johnson's hand in the tray slot when he would not move. An SDSD incident report indicated Johnson asked Deputy 2 for an extra food tray, and Deputy 2 informed him if there was extra, he would be given the extra tray. Deputy 2 stated "I was

closing the cuffing portal when I felt resistance. I looked down and saw Johnson was attempting to stick his left hand out. I told Johnson to move his fingers. Johnson complied and accused of me knowing that he had his fingers outside the cuffing portal. I told Johnson I did not see his fingers there.” Deputy 2 stated in his report, “Johnson requested three grievances and informed me that he was going to CLERB and get me fired for cruel and unusual punishment.” Deputy 2 asked Johnson if he wanted to be seen by medical, but he refused and stated he was not in physical pain. The evidence showed the incident did occur but was accidental and not a deliberate attempt to hurt or harm Johnson. Furthermore, Johnson refused medical care and stated he was not in physical pain. While the evidence showed the incident occurred there was insufficient evidence to determine ill intent. There was insufficient evidence to either prove or disprove the allegation.

4. Misconduct/Procedure – Unidentified deputies failed to accept, sign and/or respond to Johnson’s grievances.

Board Finding: Action Justified

Rationale: Johnson alleged “obstruction of justice” for grievances not being signed, accepted, and those accepted have no response. According to SDSL DSB P&P N.1 titled “Grievance Procedure”, states Incarcerated Persons may use the grievance procedure for complaints related to any aspect of condition of confinement that directly and personally affects the Incarcerated Person grievance. The policy states, this includes food, clothing, and bedding. SDSL records showed Johnson is a chronic complainer who submitted multiple grievances to include but not limited to: staff complaints, pencil sharpening, lack of privacy while using the restroom, dayroom time, orthopedic soft shoe request, lack of deputy grievance acceptance, dirty cells, and medical care. Most of the grievances were lengthy and nonsensical. Many of the grievance forms were indicted to be incarcerated person requests and were indicated as forwarded to the perspective authority. Per policy if a grievance is determined to be a request, then a J-21 (Inmate Request Form) will be provided to the IP and no JIMS entry is required. Furthermore, per policy complaints against staff are not grievances and will be handled as a complaint against staff. The immediate supervisor of the employee named in the complaint determines if a formal investigation is warranted, and if so, the supervisor will forward to Internal Affairs. There was one grievance in which it was indicated that Johnson refused to speak with the receiving staff member. Additionally, on one grievance it was indicated for Johnson to only put one complaint per grievance. Based on the evidence Johnson continuously used the grievance procedure for inmate requests and staff complaints and SDSL staff informed him of such. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

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**SUMMARY DISMISSAL (0)**

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*End of Report*

**NOTICE**

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