County of San Diego

CITIZENS' LAW ENFORCEMENT REVIEW BOARD

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SPECIAL MEETING AGENDA
Thursday, June 27, 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 (1 minute)**

2. **STATEMENT (just cause) and/or consideration of a request to participate remotely. (emergency circumstances) by a Board Member, if applicable. Voting item as necessary (0 minute)**

3. **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 no more than three minutes; however, the time allotted for in-person, virtual, and written public comment may be adjusted by the Board Chair at their discretion. 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.

4. MINUTES APPROVAL (2 minutes)

a) Draft Meeting Minutes for May 28, 2024

5. PRESENTATION/TRAINING

a) None

6. EXECUTIVE OFFICER'S REPORT (5 minutes)

a) Overview of Activities of Chief Deputy and Staff

b) Workload Report – Open Complaints/Investigations Report (Attachments B)

c) Case Progress and Status Report (Attachments C)

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

e) San Diego Sheriff's Department response to CLERB Policy Recommendation "Provision of Eviction Documentation In Threshold languages" (Attachment E)

f) San Diego Sheriff's Department response to CLERB Policy Recommendation Case #21-117/TUCK (Attachment F)

7. BOARD CHAIR'S REPORT (5 minutes)

8. NEW BUSINESS (10 minutes)

a) Update and Election of CLERB Officers for FY 24/25

9. UNFINISHED BUSINESS

a) Review and Approval of Minor Edits to CLERB Policies & Procedures Guidelines for conformity with CLERB Rules & Regulations (Attachment G)

10. BOARD MEMBER COMMENTS (10 minutes)

11. BOARD MEMBER QUERY for SHERIFF/PROBATION LIAISON(S) (10 minutes)

12. CLOSED SESSION: TIME CERTAIN – 7:30 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).

b) PUBLIC EMPLOYMENT RECRUITMENT
Notice pursuant to Government Code Section 54957(b)
Title: Executive Officer, CLERB

CASES FOR SUMMARY HEARING (13)

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)

22-113/FOSBINDER (Inv. Chiesa)

1. Death Investigation/Drug Related – Joshua Fosbinder, while an inmate at San Diego Central Jaill, was found unresponsive in his cell on 09-18-22.

   Recommended Finding: Not Sustained
   Rationale: The evidence supported that Joshua Fosbinder was properly classified upon his entry into the SDSD jail system after his arrest. SDSD records showed Fosbinder was cleared to classification by medical staff, medical decisions including "fit for jail" status are made by medical personnel over whom CLERB has no jurisdiction. According to SDSD records, there was no keep separate orders noted between Fosbinder and his cellmates. SDSD records showed on 09-15-22, Fosbinder was transported to court for court proceedings and returned that night. The evidence showed Fosbinder was not scanned after his court proceedings. SDSD showed Fosbinder was moved into housing area 4B, cell #18 on 09-16-22. His cell mate [redacted] was moved to house 4B cell #18 on 08-31-22 and [redacted] on 09-18-22. SDSD records showed [redacted] was body scanned on 09-17-22, however the body scan was performed with his face and chin facing down. Per body scanning training materials, it is recommended body scans are performed with IPs facing forward and chin up. The evidence showed the safety and counts conducted prior to Fosbinder's discover were conducted in accordance with policy. Furthermore, it was noted on the last check, five minutes prior to Fosbinder going man-down, Fosbinder and his cellmates were awake and appeared to be in good health in their cell. The evidence showed on the 09-18-22 at approximately 9PM, Fosbinder and his cellmate were found unresponsive in their cell. Upon being advised of Fosbinder going mandown, sworn personnel expeditiously responded and immediately initiated lifesaving measures until relieved by a paramedic emergency response team. A total of nine doses of Naloxone were administered and four doses of epinephrine. An AED and Lucas CPR device were used on Fosbinder as part of lifesaving measures. After approximately 20 minutes of CPR, a pulse was obtained. Fosbinder was transported to a hospital where he had a return of spontaneous circulation, diffuse cerebral edema was found, and he was submitted to the Intensive Care Unit. On 09-21-22, Fosbinder's first and second brain deaths were pronounced. The cause of death was toxic effects of fentanyl, and the manner of death was accident. Toxicology testing of blood specimens collected did not detect any drugs in Fosbinder's system, however a urine drug screen was positive for fentanyl and norfentanyl. Furthermore, white residue was found at the scene. The result of the lab report indicated the residue was fentanyl. Although SDSD has implemented numerous measures to deter drugs from entering its detention facilities, there is no doubt that Fosbinder while as an incarcerated person in the custody and under the care of the SDSD, either acquired or possessed and subsequently consumed fentanyl, which resulted in his death. According to the SDSD News Release, "Stopping Drug Smuggling in County Jails", dated 04-19-21, the SDSD is active in their attempts to intercept drugs into the facilities. Some efforts being made are the use of body scanners at all intake facilities and the George Bailey Detention Facility and inmate screening and flagging of potential smugglers. Also, the Mail Processing Center has special equipment for drug detection, drug detection K-9's, and a "no questions asked" drug drop box. SDSD also provides drug education and awareness in the facilities. Additionally, in accordance with DSB P&P I.41, Inmate Cell Searches and DSB P&P L.2 Sanitation and Hygiene Inspections, cell searches and inspections were performed to provide a safe and secure environment free of contraband. SDSD documentation showed the last search conducted prior to the incident was a visual cavity of IPs performed 09-08-22 and the results indicated no contraband was found. The last cell search conducted for module B was 07-14-22 with no results indicated on the Area Activities Summary Report. In CLERB case #22-053/Ornelas CLERB recommended SDSD require body scans for IPs transferred to and from court and/or canine dogs for IPs re-entering jails from court. On 02-13-24, CLERB re-submitted a policy recommendation to search or scan all persons entering Detention Facilities. These policy recommendations are still pending a response from the department. The investigation failed to definitively determine how the fentanyl contributing to Fosbinder's death entered the detention facility, there was insufficient evidence to either prove or disprove misconduct on the part of SDSD sworn personnel.

2. Misconduct/Procedure – Unidentified SDSD staff failed to keep drugs out of jails.

   Recommended Finding: Sustained
   Rationale: Although SDSD has implemented and taken measures to deter drugs from entering their jails, Fosbinder acquired fentanyl which consequently contributed to his death. Despite all interdiction efforts, there is no doubt that Fosbinder, while as an incarcerated person in the custody and under the care of the SDSD, acquired and took fentanyl, which contributed to his death. The investigation failed to confirm how the fentanyl entered the detention facility. The evidence indicated that SDSD personnel failed to prevent illicit drugs from entering the detention facility and that act or conduct was not justified.

3. Misconduct/Procedure – Deputy 1 failed to properly scan an Incarcerated Person (IP).

   Recommended Finding: Unfounded
   Rationale: Through the course of investigation, it was discovered the body scans of an IP were conducted with their head down on 09-17-22. Training policy for both the Soter RS Scanner and Tek84 recommends performing body scans with the individual facing forward. While training recommends individuals are scanned facing forward, it is a recommendation and not a requirement. As such there was no policy violation. The SDSD initially identified Deputy 1 as having performed the scans, but on 04-09-24 CLERB was notified that Deputy 1 did not perform the scans. The evidence showed the act or conduct did not occur.

POLICY RECOMMENDATION:

1. It is recommended that the Sheriff's Department employ personnel with a special expertise and background in both image reading and medical to conduct and read body scans at SDSD facilities.

23-013/THURESSON (Inv. Klew)

1. Death Investigation/Drug-Related – Ryan Patrick Thuresson died while in the custody of the Sheriff's Department on 02-04-23.

   Recommended 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. Documents received from the San Diego Sheriff's Department (SDSD) showed that Ryan Thuresson, the decedent, was initially booked into the custody of SDSD following an arrest by San Diego Police Department 10-04-22. Documents showed that on 02-01-23, Thuresson was housed at Vista Detention Facility (VDF) and a deputy conducting a security check in Module 5 noticed Thuresson was unresponsive. A medical response was initiated and Thuresson was transported to a nearby hospital. On 02-04-23, Thuresson was declared deceased. On 02-10-23, the San Diego Medical Examiner's Office (SDMEO) conducted an autopsy of Thuresson at the SDMEO. The cause of death was combined fentanyl and fluorofentanyl toxicity, and the manner of death is accident. Toxicology testing of antemortem blood specimens were positive for Fentanyl, including 4-ANPP, which would indicate the substance the decedent ingested was illegally manufactured. 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 released for the death of Thuresson stated, "The CIRB conducted a preliminary review of this incident on March 15, 2023, with no action items or policy recommendations at that time." The release also reported the cause of death as stated in the SDMEO report. In CLERB case #22-053/Ornelas, CLERB made three recommendations to CIRB reviews which included: 1. Post Critical Incident Review Board (CIRB) Reviews on the SDSD website within 10 days of the review. 2. Update CIRB Reviews on the SDSD website within five days of obtaining applicable information. And 3. Include all contributing causes of death in the CIRB Review posted on the SDSD website. The policy response is still pending from the department. 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 SDSD. The evidence supports 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: See Rationale #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 SDSD. On 02-14-24, CLERB resubmitted a policy recommendation to SDSD. The synopsis of the policy recommendation is that SDSD physically search, or body scan all persons entering a SDSD-operated detention facility, to include all SDSD employees, County employees, contractors, and those persons conducting county-related business. "All persons" also includes social and professional visitors and incarcerated persons (I/Ps) upon booking and transferring between facilities or re-entering a facility after having departed it for court, medical treatment, etc. The evidence supports the allegation and the act or conduct was not justified.

3. Misconduct/Procedure – SDSD failed to conduct timely safety checks.

   Recommended Finding: Sustained
   Rationale: A review of the safety checks conducted around the time Thuresson was found unresponsive was completed. SDSD Detention Services Policies and Procedures (DSB P&P) Section I.64, Safety Checks: Housing and Holding Areas of Incarcerated Persons, stated, "Sworn staff will conduct safety checks of incarcerated persons, housing areas, holding areas and vacant cells through direct visual observation (i.e., direct personal view of the incarcerated person/area without the aid of audio/video equipment). Safety checks of incarcerated persons consist of looking at the incarcerated persons for any obvious signs of medical distress, trauma or criminal activity. Safety checks shall be conducted at least once within every 60-minute time period." Additionally, Title 15, Section 1027.5, Safety Checks, stated, "Safety checks will determine the safety and well-being of individuals and shall be conducted at least hourly through direct visual observation of all people held and housed in the facility. There shall be no more than a 60-minute lapse between safety checks." CLERB's investigation revealed, based upon a review of CCTV footage, that approximately 61 minutes and 15 seconds elapsed between last direct observation of Thuresson and the direct observation which showed Thuresson was unresponsive. It is unknown whether the one-minute and 15-second delay in mandated direct visualization of Thuresson would have prevented his death, however, this issue of practice versus policy was raised in a previous CLERB case. In CLERB case #21-069/Rodriguez, a death case, CLERB's investigation revealed that 65 minutes and 28 seconds elapsed between direct observations. In that case, a policy recommendation was sent to SDSD on 12-18-22, which stated, "It is recommended that SDSD take all necessary measures to change its current practice to conform with statute and its own existing policy by mandating that every incarcerated person be directly observed by sworn staff at random intervals not to exceed 60 minutes (30 minutes for Medical Observation Beds and in Psychiatric Stabilization Units and 15 minutes for safety cells), as opposed to simply ensuring the safety checks start within the mandated time-period." In this case, as in case 21-069, Title 15 and SDSD's policies mandate the direct visual observation of incarcerated persons with no more than a 60-minute lapse between the direct visual observations. SDSD's current practice, however, is to start safety checks within the 60-minute time-period but not necessarily to directly visualize each incarcerated person within that time-period, thus resulting in innumerable instances where incarcerated persons are not directly visually observed within statutorily mandated time-periods. CLERB's position is that this delay was in violation of SDSD policy and Title 15, however, as the current SDSD practice allows for the starting of the checks within the 60-minute period, no matter when the actual direct visualization occurs, even if that visualization is outside of the 60-minute period, a sustained finding will not be recommended against the involved deputies following the standard practice but, instead, against the SDSD itself for knowingly allowing practices that routinely violate Title 15 and its own policy and procedures. As such, the evidence indicates the conduct occurred and was not justified.

23-068/ORNELAS (Inv. Aldridge)

1. Death Investigation/In-Custody Suicide – Incarcerated Person Pedro Junior Ornelas III was found hanging in his jail cell on 06-26-23.

Recommended Finding: Action Justified
Rationale: This case was reviewed in accordance with CLERB Rules & Regulations Section 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. Incarcerated Person Pedro Junior Ornelas III was incarcerated at the San Diego Sheriff's Department (SDSD) San Diego Central Jail (SDCJ) after his 06-16-23 arrest. Ornelas was housed alone in his jail cell. On the night of 06-26-23, Sheriff's detention deputies were performing their safety/security checks when they found Ornelas unresponsive and hanging by a ligature in his jail cell. Upon being discovered, deputies and jail medical/health staff immediately responded and initiated cardiopulmonary resuscitation. Paramedics were summoned to the scene. Upon paramedic's arrived, cardiopulmonary resuscitation was continued, and Ornales was transported to UCSD Medical Center. Despite medical intervention, Ornelas' health deteriorated, and his death was pronounced on 06-28-23. On 06-29-23, the San Diego County Medical Examiner's Office (SDCMEO) conducted an independent investigation and post-mortem examination of Ornelas. The SDMEO determined the cause of Ornelas' death to be "Anoxic-Ischemic Encephalopathy, due to Resuscitation Cardiopulmonary Arrest, due to Asphyxia, due to Hanging" and the manner of death was "Suicide." Toxicology testing of blood specimens revealed positive results for THC cannabinoid. The evidence indicated that Ornelas was properly classified upon his entry into the SDSD jail system. Jail documents, coupled with jail surveillance video recordings of Ornelas' module, his tier, and his cell revealed at all safety/security checks were performed in a timely manner and were in accordance with the department's policy and procedures. Prior to the incident, the last safety/security check was performed at approximately 6:01pm. A deputy conducted the safety/security check and approached Ornelas' jail cell. In the jail surveillance video recording, Ornelas was seen standing at the cell door as the deputy approached. After the deputy completed the safety/security check, Ornelas was observed to occasionally stand or move around in front of the window of the cell door. At 6:21pm, Ornelas was seen standing in front of the cell window for a short duration. This was the last time Ornelas was seen moving about in his cell. During his incarceration, there was evidence that Ornelas expressed concern about his mental wellbeing to others; however, that there was no evidence that that information was relayed to SDSD staff. Per SDSD Policy & Procedure Section 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 Ornelas stated, "The CIRB conducted a preliminary review of this incident on 08-16-23 with no action items or policy recommendations at that time." In the past, CLERB made three recommendations to CIRB reviews which included: 1.) Post Critical Incident Review Board (CIRB) Reviews on the SDSD website within 10 days of the review. 2.) Update CIRB reviews on the SDSD website within five days of obtaining applicable information. And 3.) Include all contributing causes of death in the CIRB Review posted on the SDSD website. The policy response is still pending from the department. There was no evidence to support an allegation of procedural violation, misconduct, or negligence on the part of Sheriff's Department sworn personnel.

2. Misconduct/Procedure - Unidentified deputies housed Ornelas alone in his jail cell.

Recommended Finding: Action Justified
Rationale: Ornelas' mother submitted a signed complaint with additional questions/allegations regarding Ornelas' death. In her complaint to CLERB, Ornelas' mother questioned, "*Why was he* [Ornelas] *in a 3-man cell alone? His cellmate contacted me upon his release he was taken to be a trustee and my son was alone. Why?*" It was noted that prior to the incident, Ornelas was housed with two cellmates. Prior to Ornelas' suicide attempt, one of the cellmates had been transferred to a different jail, and the other cellmate was transferred to another module. In the jail setting, there are several reasons why an incarcerated person may be housed with a cellmate rather than being housed alone. Incarcerated persons are usually housed together to allow for more efficient use of limited space within the jails, and in some cases, housing incarcerated persons together may enhance safety by providing mutual supervision and emotional support. Having a cellmate may deter violence and self-harm incidents by providing someone to intervene or seek help if necessary. Inmate movement within jails is a routine aspect of institutional management, a combination of security, safety, administrative, and individual needs to be considered. Having a cellmate could have provided additional

oversight and support to Ornelas to prevent his suicide attempt; however, there was no evidence to indicate that either Ornelas, nor his cellmates, nor anyone else had informed jail staff that Ornelas was suicidal. It was unknown to jail staff that Ornelas was struggling with mental health issues, or that having a cellmate may have provided emotional support for him at that time. Housing Ornelas alone in his jail cell was not a violation of policy, nor did it go against best practices given the lack of information. The evidence showed that the alleged act or conduct did occur, and it was lawful, justified and proper.

3. Misconduct/Procedure - Unidentified deputies failed to read/scan Ornelas' outgoing mail.

   Recommended Finding: Action Justified
   Rationale: In Ornelas' mother's complaint to CLERB she also questioned, "*Why wasn't his mail being read [by deputies]. His girlfriend received a letter where he says he is planning this!!!*" In usual jail operations, deputies at the Mail Processing Center (MPC) scan and monitor incoming and outgoing mail for contraband, such as drugs, weapons, or other prohibited items that may be hidden within the mail. The deputies scan the mail, versus reading each incoming and outgoing article of mail. Scanning mail typically refers to the practice of inspecting or examining letters, packages, or other forms of communication sent to incarcerated persons. This process aids in the SDSD's efforts to prevent contraband, namely drugs, from entering the facility. While they do search every article of mail for contraband, they don't read every letter. The purpose of SDSD DSB P&P Section P.3 titled "Incarcerated Person Mail," is to establish guidelines for the uniform handling, screening and prompt routing/delivery of mail and states that all incoming non-legal mail will be routed to the Mail Processing Center (MPC) warehouse. The evidence showed that the alleged act or conduct did occur, and it was lawful, justified and proper.

4. Misconduct/Procedure - Unidentified deputies failed to monitor Ornelas' outgoing phone calls.

   Recommended Finding: Action Justified
   Rationale: In Ornelas' mother's complaint to CLERB, she questioned, "*How come his phone calls were not monitored, especially* [with him being] *on a federal hold*?" CLERB conducted a review of all phone calls made Ornelas during his incarceration. In usual jail operations, deputies do not listen to every phone call that incarcerated persons make. While the SDSD does monitor some IP communications for security purposes, such as to prevent illegal activities or maintain order, they typically focus their monitoring efforts on calls that are deemed suspicious or pose a potential risk. The SDSD may randomly monitor calls or target specific individuals or groups for surveillance based on intelligence or suspicion of wrongdoing. The purpose of SDSD DSB P&P Section P.2 titled "Telephone Access," is to establish guidelines that will permit incarcerated persons to use telephones during normal operating procedures. All incarcerated persons will be provided reasonable access to a telephone. The purpose of SDSD DSB P&P Section P.17 titled "Monitoring Telephone Calls/Visits/Mail," is to establish guidelines for monitoring incarcerated person telephone calls, in-person social visits, video social visits, and mail in accordance with statute and case law. All telephone calls made by incarcerated persons will be recorded unless the call is made to a number that is privileged. The evidence showed that the alleged act or conduct did occur, and it was lawful, justified and proper.

5. Misconduct/Procedure – Unidentified deputies did not place Ornelas "on suicide watch."

   Recommended Finding: Action Justified
   Rationale: In Ornelas' mother's complaint to CLERB she questioned, "*How could you not have him on a suicide watch? Four years ago, he was on a suicide watch in your facilities. Does that not stay somewhere in his records?*" In review of Ornelas' jail documents, during this incarceration, he was not placed in a safety cell, nor was he placed in an Enhanced Observation Housing (EOH) unit. Specialized housing for suicidal individuals is typically implemented when there is a concern that the incarcerated person may harm themselves. In Ornelas' case, it did not appear that staff was aware of his current suicidal ideations. The SDSD conducts assessments to evaluate the risk of self-harm and/or suicide for each incarcerated person. Factors such as mental health history, behavior, and current circumstances are considered. Incarcerated persons who are deemed to be at high risk may be placed in a safety cell, while others may not require such a high level of monitoring. Placement in a safety cell or specialized housing is a tool the SDSD uses to protect incarcerated persons who are deemed to be at risk of self-harm or suicide. Though Ornelas had a past history of expressing his suicidal ideations, at the time of his current incarceration, staff was unaware that Ornelas

was in danger of harming himself, and so was not deemed to be at high risk. The purpose of SDSD DSB P&P Section J.5 titled "Suicide Prevention Practices for Incarcerated Persons & Detentions Safety Program," is to set forth procedures for detention staff to identify those incarcerated persons who may be an elevated risk for self-harm or suicide. Incarcerated persons who are recognized and observed as being a potential self-harm or suicide risk shall be assessed for consideration of placement into one of the defined Detentions Safety Program (DSP) housing options. Though Ornelas had expressed his suicidal ideations to others, that information was not shared with jail staff. As such, Ornelas did not appear to fit the criteria to be considered as an elevated risk for self-harm or suicide. According to SDSD DSB P&P Section J.1 titled "Safety Cells: Definition and Use," incarcerated persons who have been assessed for Inmate Safety Program (ISP) housing in compliance with Detention Services Bureau Policies and Procedures (DSB P&P) section J.5 may be temporarily placed in a safety cell when they are actively self-harming or actively assaultive. Incarcerated persons may be placed in a safety cell temporarily if they are actively self-harming or actively assaultive. The purpose of SDSD DSB P&P Section J.4 titled "Enhanced Observation Housing (EOH): Definition and Use," is to set forth procedures ensuring incarcerated persons who meet the criteria are housed in Enhanced Observation Housing (EOH) to prevent self-harm and suicides. The allegation that the SDSD did not place Ornelas in specialized housing was justified, given their lack of acknowledge of his current mental state.

6. Misconduct/Procedure – Deputy 1 used an unknown device to cut Ornelas' ligature.

   Recommended Finding: Not Sustained
   Rationale: During this investigation, there was a concern of what tool, device, or instrument Deputy 1 used to cut the ligature that Ornelas used to hang himself. A review of all evidence did not reveal what instrument Deputy 1 used to cut the makeshift noose. California Penal Code §4574 makes bringing a weapon, including a pocketknife or folding knife, into a detention facility a felony. Since there was a lack of evidence or documentation on what Deputy 1 used to cut the ligature, there was a concern for facility safety and security. Detention facilities have strict rules and regulations regarding what items individuals can and cannot bring into jail facilities. Unauthorized instruments can pose significant risks within a detention setting. To maintain order, prevent violence, and ensure the safety of everyone within the facility certain items are typically prohibited. Deputy 1 was served with and responded to a Sheriff's Employee Response Form (SERF) and provided confidential information 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. Additionally, a scene investigation was performed of the SDCJ. While on scene, it was demonstrated that that the SDSD equipped housing deputies with a rescue tool or device. Moreover, it was noted that each deputy interviewed by CLERB also possessed a rescue tool that they had purchased on their own to carry while on duty to not be solely dependent on department issued equipment. The preponderance of evidence indicated that Deputy 1 had access to an authorized tool; however, there was insufficient evidence to either prove or disprove the allegation that the tool or device that Deputy 1 used was a SDSD authorized tool or device.

USES OF FORCE RESULTING IN GREAT BODILY INJURY (0)

PRIORITY (1)

23-071/HUNTE (Inv. Wigfall)

1. Misconduct/Procedure – Deputy 3 ordered Jerimiah Hunte to "get on the ground."

   Recommended Finding: Unfounded
   Rationale: Complainant Hunte reported that on 01-22-23, a "citizen pulled a knife and went after him." Hunte reported he flagged down Deputy 3, who responded and yelled at Hunte, "Get on the ground!" Hunte reported he did not get on the ground out of fear for his safety as an "African American male." BWC showed that Deputy 3 arrived on scene with two subjects engaged in a verbal altercation and said, "Both of you sit down, so we could figure out what's going on." Deputy 3 attempted to de-escalate the situation as he spoke in a

calm manner and approached the scene to assess what happened. Body Worn Camera (BWC) evidence showed Hunte spoke in a loud manner, seemed agitated and did not allow the deputy the opportunity to investigate the incident. Deputy 3 attempted to speak with Hunte who continued to speak over him and walked to and from the scene several times. Deputy 3 then called in an "active disturbance." The evidence showed the alleged act or conduct did not occur.

2. Misconduct/Procedure – Deputies 1 and 2 ordered Hunte to "get on the ground."

   Recommended Finding: Action Justified
   Rationale: Complainant Hunte reported deputies yelled at him to, "Get on the ground!" See Rationale #1. SDSD documentation showed that Deputies 1 and 2 responded to Deputy 3's call for assistance and upon arrival, Hunte seemed agitated and was uncooperative. BWC evidence showed Deputies 1 and 2 ordered Hunte to "get on the ground" as they attempted to detain him. Per the California Peace Officer Legal Sourcebook, (CPOLS) Search and Seizure, when Hunte waived down Deputy 3 that was a "consensual encounter" as the contact between the two was voluntary. Once Deputy 3 called in an "active disturbance" deputies responded with "the purpose to resolve whether suspicious behavior is innocent or relates to crime," which led to a detention. CPOLS also states that a detention is an exertion of authority that is something less than a full-blow arrest but more substantial than a simple "contact." Therefore, it was reasonable to command a suspect to "get on the ground," especially if a deputy is not aware of the circumstances, the suspect is agitated, and they need to investigate the situation. Deputies 1 and 2 responded to Sheriff Employee Response Forms (SERF) and provided confidential statements that were used in the determination of these findings. The evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

3. Discrimination/Racial – Deputies 1 - 3 treated two suspects differently.

   Recommended Finding: Action Justified
   Rationale: Complainant Hunte reported he was a victim who flagged down a deputy for assistance but was "profiled and targeted" based on his race. Hunte stated, "As an African American, I felt they were just trying to get me on the ground and treated me like I did something wrong." Hunte denied that deputies made any statements that implied racial bias, nor were any statements captured on BWC of that nature. SDSD P&P 2.55 Non-Bias Based Policing states that members of the San Diego County Sheriff's Department are prohibited from inappropriately or unlawfully considering race and ethnicity in deciding whether enforcement intervention will occur. Policy also states that all investigative detentions and arrests by employees will be based on a standard of reasonable suspicion or probable cause as required by the Fourth Amendment of the U.S. Constitution. Although deputies did not use force on the other suspect, he was detained and arrested by deputies as well. Given the other subject was cooperative with deputies, harsh commands and/or force was not needed. Therefore, it was reasonable that deputies confronted and handled each suspect differently. Deputies 1 and 2 responded to a SERF and provided confidential statements that were used in the determination of these findings. The evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

4. Excessive Force – Deputies 1 and 2 tased Hunte.

   Recommended Finding: Not Sustained
   Rationale: Complainant Hunte reported that deputies tased him as he was "getting on the ground." Sheriff's Policy 2.49, Use of Force, states employees shall not use more force in any situation than is reasonably necessary under the circumstances. Addendum F, Use of Force Guidelines, states deputies shall utilize appropriate control techniques or tactics which employ maximum effectiveness with minimum force to effectively terminate or afford the deputy control of the incident. Deputies attempted several times to gain Hunte's voluntary compliance but were unsuccessful. Deputies explained they wanted to determine what occurred and warned Hunte if he did not comply, force would be used. Hunte continued to speak over deputies and did not comply. Deputy reports stated Hunte displayed a "bladed/fighting" stance (assaultive behavior) and took a step toward Deputy 1 right before deputies deployed their Conducted Energy Devices (CED). This was somewhat confirmed by BWC which showed a shirtless Hunte saying, "this is not right." Hunte had his arms at his side, "puffed" up his chest, raised his chin up and slowly turning toward Deputy 1 and said, "yeah do what you do bitch, go ahead" as he was tased. Deputies interpreted Hunte's "bladed

stance" as assaultive behavior, but Hunte described his "stance" as "standing up for myself as he took a deep breath, stood tall and prepared to get on the ground." Deputies 1 and 2 responded to a SERF and provided confidential statements that were used in the determination of these findings. There was insufficient evidence to either prove or disprove the allegation.

5. False Arrest – Deputy 2 arrested Hunte.

   Recommended Finding: Not Sustained
   Rationale: Complainant Hunte reported deputies arrested him. Hunte stated he was booked into Vista Detention Facility, (VDF) released on bail after several hours, and his charges were dropped when he went to Court. Per SDSD documentation, Deputy 2 responded to an active disturbance, which gave him the authority to detain Hunte to gather further information. Hunte's behavior escalated which led to a use of force and then an arrest for Penal Code 69, Resisting Executive Officer. CPOLS describes this code as "Every person who attempts, by means of any threat or violence, to deter or prevent an executive officer from performing any duty imposed upon the officer by law…" As documented in Rationale #4, deputies described Hunte as assaultive, but there was insufficient evidence to prove or disprove the allegation.

6. Misconduct/Procedure – Deputies 1 and 3 failed to provide identifying information upon request.

   Recommended Finding: Not Sustained
   Rationale: SDSD P&P 2.20 Identification states," While on duty, all employees shall furnish their first and last name and/or ARJIS number to any person requesting his or her identity, except when the withholding of such information is necessary for the performance of police duties." As heard on BWC, Hunte asked deputies to "identify themselves", but deputies did not provide their name and/or ARJIS number. Hunte asked Deputy 3, "What is your name" and "identify your fucking self man." Deputy 3 just paused in response. BWC confirmed Deputy 1 attempted to respond, but Hunte spoke over him. Deputies 1 and 3 also responded to a SERF and provided confidential statements that were used in the determination of these findings. It was unknown if the "withholding of their information was necessary for the performance of police duties," therefore there was insufficient evidence to either prove or disprove the allegation.

7. Misconduct/Procedure – Deputy 2 failed to provide identifying information upon request.

   Recommended Finding: Unfounded
   Rationale: SDSD P&P 2.20 Identification states," While on duty, all employees shall furnish their first and last name and/or ARJIS number to any person requesting his or her identity, except when the withholding of such information is necessary for the performance of police duties." As heard on BWC, Hunte asked deputies to "identify themselves." Deputy 2 was initially unresponsive with the requested information but subsequently provided Hunte with his name and ARJIS number. Deputy 2 also responded to a SERF and provided a confidential statement that was used in the determination of these findings. The evidence showed the alleged act or conduct did not occur.

8. Misconduct/Procedure - Deputy 1 failed to utilize de-escalation techniques.

   Recommended Finding: Not Sustained
   Rationale: Addendum F, Use of Force Guidelines describes de-escalation as "actions taken in an attempt to stabilize an incident in order to try and reduce the immediacy of a threat by obtaining more time, tactical options or resources to resolve the incident. The goal of de-escalation is to gain voluntary compliance of subjects, when feasible, and or to potentially reduce or eliminate the need to use force on a subject. De-escalation does not require that a deputy risk their safety or the safety of the public." Upon Deputy 1's arrival on scene, he exited his patrol vehicle with taser in hand and immediately ordered Hunte to the ground or he would be tased. Deputy 1 approached Hunte in an "authoritative manner" as opposed to a "calm demeanor" and repeatedly ordered Hunte to the ground under threat of taser. According to Deputy 1's Officer Report, he utilized de-escalation techniques when he attempted to explain the situation and have Hunte sit on the ground. When deputies are faced with a situation where discretion can be exercised, they must evaluate the circumstances, consider the available resources, and rely on their training, Sheriff's Department policies and procedures, statutory law, information-led policing, and supervision in making the appropriate decision.

Deputy 1 responded to a SERF and provided a confidential statement that was used in the determination of these findings. There was insufficient evidence to either prove or disprove the allegation.

ROUTINE (9)

23-077/KENYON (Inv. Wigfall)

1. Illegal Search & Seizure – Deputies 1 and 3 searched a vehicle occupied by Jenna Kenyon.

   Recommended Finding: Action Justified
   Rationale: Complainant Kenyon reported that the vehicle was searched because she was on Probation and had a Fourth Waiver. A Fourth waiver is when a person has "waived" their fourth amendment rights to a warrantless search, often placed as a condition of their probation. She reported, "It is my understanding that he (deputy) could only search my side of the vehicle and the places that are within reach." According to the California Peace Officer Legal Sourcebook (CPOLS), searches pursuant to search conditions states, "If an occupant of a vehicle is a parolee, you may search the areas of the passenger compartment--including containers--where it is **objectively reasonable** (**emphasis added**) to expect that the parolee could have placed personal items or discarded contraband. You are not required to limit your search to just the area where a parolee is sitting." The deputies verified Kenyon had an active Fourth waiver and searched all four compartments, front and back seats. Given the size of the vehicle and the fact that they were parked for an unknown amount of time, it was objectively reasonable that Kenyon had access to more than her immediate area. The evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

2. Misconduct/Intimidation – Deputy 3 threatened to arrest Kenyon.

   Recommended Finding: Unfounded
   Rationale: Complainant Kenyon reported that she became emotional when she was advised her vehicle would be towed, she said Deputy 3 approached her and said if she did not stop crying, he would arrest her and take her to jail. Kenyon stated it is "inappropriate to use nonviolent emotions as an excuse to take her to jail." Body Worn Camera (BWC) evidence confirmed the deputy advised Kenyon that the vehicle would be towed, but they planned on releasing her with her dog without arrest. Kenyon attempted to reason with the deputy, started to cry and told him the vehicle was her "home." Deputies used discretion and did not arrest Kenyon although she was on Probation and found in a vehicle with drugs and paraphernalia. Deputy 3 did not threaten Kenyon with arrest (for crying.) SDSD P&P Section 2.22 Courtesy states employees shall be courteous to the public, tactful in the performance of their duties, shall control their tempers, exercise patience and discretion even in the face of extreme provocation and coarse, profane or violent language is generally prohibited. BWC showed Deputy 3 interacted with Kenyon in a respectful and non-threatening manner. The evidence showed that the alleged act or conduct did not occur.

3. Illegal Search & Seizure – Deputy 2 towed Kenyon's vehicle.

   Recommended Finding: Action Justified
   Rationale: Complainant Kenyon reported that deputies towed her vehicle and complained that it was "her home." SDSD documentation showed that the vehicle was towed because the driver was arrested; Kenyon was not the registered owner of the vehicle. SDSD P&P Towing policy states that any vehicle that is towed and/or stored, the removal shall be in compliance with Vehicle Code 22651 or other lawful authority. According to Vehicle Code 22651, Circumstances Permitting Removal of a Vehicle, states a peace officer may remove a vehicle if the officer arrests a person driving or in control of a vehicle. In addition, Kenyon did not have a valid driver's license, therefore deputies were unable to release the vehicle to her. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

23-090/BYWATER (Inv. Aldridge)

1. Misconduct/Procedure – Deputies 2-6 and/or an unidentified deputy disclosed Incarcerated Person (IP) Rachel Bywater's personal information on 04-09-23.

   Recommended Finding: Not Sustained
   Rationale: In a complaint to CLERB, Bywater alleged that on "*Easter 2023 officer gave personal information over loudspeaker in 4-B."* Based on the information provided, CLERB was unable to identify who Bywater alleged released her personal information. As such, all possible subject deputies were served with a Sheriff's Employee Response Forms (SERF) and were asked if they disclosed Bywater's "personal information over loudspeaker." Deputies 2-6 provided information 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. Absent information provided by an independent witness to the incident or additional video or audio recordings of the interaction, there was insufficient evidence to either prove or disprove the allegation that Deputies 2-6 disclosed Bywater's personal information on 04-09-23.

2. Misconduct/Procedure – Deputy 1 disclosed IP Bywater's personal information on 04-09-23.

   Recommended Finding: Summary Dismissal
   Rationale: See Rationale #1. Deputy 1 was identified as someone who may have been involved, and as such, was served with a SERF. At the time of this incident, Deputy 1 was an active employee of the Sheriff's Department; however, he is no longer employed by the SDSD. As per CLERB's Rules and Regulations Section 5.8 titled Termination, Resignation or Retirement of Subject Officer, the Review Board shall have the discretion to continue or terminate an investigation, if, after a complaint is filed and before the Review Board completes its investigation, the subject officer terminates employment with the Sheriff's Department or the Probation Department. The Sheriff or the Chief Probation Officer or the subject officer shall notify the Review Board when the subject officer's employment is terminated. As such, the Review Board lacks jurisdiction.

3. Misconduct/Procedure – Unidentified deputies "failed" to intervene when IP Bywater was harassed.

   Recommended Finding: Not Sustained
   Rationale: In Bywater's written complaint to CLERB, Bywater "*Reported being targeted by other incarcerated persons and deputies failure to intervene, leaving Rachel in module, where she was being harassed*." In a Grievance written by Bywater she explained, "*Some other inmates were being insulting… yelling things*" at her. When she approached and addressed the other incarcerated persons, asking them to cease their taunting of her, she explained "*the police came over and put me on lockdown. I felt like it was wrong to put me on lockdown down I was standing up for myself and they had started the verbal disagreement.*" A detention's sergeant addressed Bywater's grievance and advised that she did not receive any discipline regarding the incident and no disciplinary hearing was conducted. In a review of jail documents, there was no documentation confirming that Bywater was involved in an incident. In usual jail operations, if two incarcerated persons were having a minor verbal confrontation, the most reasonable remedy would be to separate them. Bywater did not identify a particular deputy, so no deputy was questioned regarding the incident. The LCDRF has only one psychiatric housing unit available, so it was reasonable for Bywater to remain in the same housing unit after being involved in a verbal only confrontation. There was insufficient evidence to either prove or disprove the allegation that unidentified deputies "failed" to intervene when Bywater was harassed by others.

4. Misconduct/Procedure – Unidentified deputies confiscated IP Bywater's personal and legal paperwork, and hygiene products.

   Recommended Finding: Not Sustained
   Rationale: In her written complaint to CLERB, Bywater alleged that "*Unidentified deputies took Rachel's journal and other paperwork, and never returned, including legal paperwork. Hygiene products taken by unidentified deputies*." Though Bywater failed to identify a deputy or a date of incident; it was noted that Bywater alleged that unidentified deputies took her commissary items, hygiene items, a journal, and some

court documents. Without confirming fault and to alleviate Bywater's complaint, a detentions sergeant fully replaced every item that Bywater had previously ordered through commissary. That sergeant also provided Bywater with a county claims form and instructed her to complete the form. That same sergeant also ensured that Bywater was given jail issued hygiene products and made copies of all Bywater's court documents which she provided to Bywater. It was unclear if Bywater's personal property, including her court documents, were taken by deputies; however, it is evident that sworn staff took appropriate measures to replace the items that Bywater alleged were taken. There was insufficient evidence to either prove or disprove the allegation that unidentified deputies confiscated Bywater's personal and legal paperwork.

5. Misconduct/Harassment – Unidentified deputies "harassed" IP Bywater.

   Recommended Finding: Summary Dismissal
   Rationale: In her written complaint to CLERB, Bywater reported "*Rachel reported she should be let go released. Cops are harassing her about things they shouldn't know, things about when she was a child*." In Bywater's letter to CLERB, she did not identify any particular deputy, nor did she provide a date of incident. Much of Bywater's claim, in both her written letter to CLERB, and in her jail submitted grievances, was non-sensical, unintelligible, and incomprehensible. Bywater's complaint lacked any facts necessary to conduct an investigation into the allegation that she was harassed by sworn staff during her incarceration. The allegation lacked merit.

6. Misconduct/Procedure – Unidentified deputies denied IP Bywater access to a working phone.

   Recommended Finding: Not Sustained
   Rationale: In her complaint to CLERB, Bywater explained "*Phone unavailable in module not working properly has requested to be for it to be fixed or that she be allowed to use another phone. She has not been allowed to use another phone and the one she has access to has not been fixed*." During this investigation, Bywater called CLERB and spoke with staff several times from a phone in her unit. Bywater sounded far away and could not be understood due to heavy static on the line. CLERB submitted a request for the facility's maintenance requests for the phones. It was noted that the Department did not maintain any maintenance logs for the phones used by incarcerated persons. According to SDSD DSB P&P Section P.2 titled "Telephone Access," all incarcerated persons will be provided reasonable access to a telephone. According to SDSD DSB P&P Section G.1 titled "Maintenance Request," each facility will ensure the timely completion of routine, urgent and/or emergency maintenance. Each facility will establish a procedure for the handling of routine maintenance requests. This procedure will include, but is not limited to, documenting needed repairs, notification of maintenance personnel, and follow-up on requested repairs. There was insufficient evidence to either prove or disprove the allegation that unidentified deputies denied Bywater access to a working phone.

7. Misconduct/Procedure – Unidentified deputies failed to provide breakfast meals to IP Bywater.

   Recommended Finding: Sustained
   Rationale: In her written complaint to CLERB, Bywater advised that unidentified deputies failed to provide her with breakfast meals. Bywater reported, "*unidentified deputies have not given breakfast a few times*." According to SDSD DSB Section K.1 titled " Provision of a Nutritionally Adequate Diet," all incarcerated persons will be provided a diet which meets or exceeds Title 15 regulations. According to SDSD DSB Section K.15 titled "Serving Times and Distribution of Meals," the Food Services Division (FSD) personnel will serve meals three times in any 24-hour period. In review of the jail surveillance video recordings of breakfast distribution, dated 07-20-23, 07-21-23, and 07-23-23, it appeared that Bywater was not offered a breakfast meal on 07-21-23. No jail surveillance video recordings was supplied to CLERB for 07-22-23. As such, CLERB was unable to confirm or refute that Bywater was supplied a breakfast meal on 07-22-23. The evidence supports the allegation that unidentified deputies failed to provide a breakfast meal to Bywater on at least one occasion, and the act or conduct was not justified.

8. Misconduct/Procedure – An unidentified deputy failed to process IP Bywater's grievance.

Recommended Finding: Sustained
Rationale: During the course of this investigation, and in review of Bywater's submitted Inmate Grievances, it was discovered that the grievance was not processed according to SDSD policies and procedures. Bywater submitted a written grievance, which was retained in her jail booking file, indicating that it was handled by jail staff; however, it was not processed according to policy. Bywater's complaint should have been processed according to SDSD Detention Services Bureau Policies and Procedures Section N.1 titled "Grievance Procedure." According to the policy, an incarcerated person may submit written grievances directly to deputies or other employees. The deputy or other employee who initially receives a grievance will print their name, ARJIS number, date and time on the grievance form and they would be responsible for entering it into the jail management computer system. Failing to process Bywater's grievance was a violation of SDSD P&P Section 2.27 titled "Neglect of Duty," and DSB P&P Section N.1 titled "Grievance Procedure." The evidence supported the allegation that an unidentified deputy failed to process Bywater's grievance did occur and the action was not justified.

9. Misconduct/Medical – Jail medical/health staff did not provide medical help to Bywater.

Recommended Finding: Summary Dismissal
Rationale: Bywater stated, "*Rachel reported not getting Medical help when she thought she was having a heart attack*." Bywater did not identify the date of occurrence or a specific timeframe for her alleged medical emergency that she claimed to have experienced. Without additional clarifying information, CLERB was unable to confirm or refute that jail medical/health staff did not provide medical help to Bywater. According to SDSD DSB P&P Section M.1 titled "Access to Care," any incarcerated person in the custody of the San Diego Sheriff shall have quality and timely access to care for their medical, dental and mental health needs. 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 incarcerated person's emergency medical needs. In any situation requiring medical response, emergency medical care shall be provided with efficiency and speed without compromising security. If the incarcerated person's condition is believed to be life threatening, sworn staff shall immediately notify on-duty health staff and provide basic life support (BLS) and/or first aid care. According to SDSD DSB P&P Section M.15 titled "Sick Call," incarcerated persons shall have access to appropriate medical and mental health services on a daily basis. Sick call procedures are explained by health staff to each newly arrested incarcerated person at the time of receiving screening. CLERB does not have any jurisdiction against the Medical Services Division. 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. Medical treatment and care are made by jail medical staff and as such CLERB lacks jurisdiction to investigate further. The Review Board lacks jurisdiction.

23-093/AUSTIN (Inv. Wigfall)

1. Misconduct/Procedure – Unidentified deputies denied Incarcerated Person (IP) Austin a shower.

Recommended Finding: Sustained
Rationale: Austin reported that he was placed in "the hole" from 07-28-23 to 08-05-23 and was "not allowed his shower time." SDSD documentation showed that on 07-28-24 Austin was transferred between facilities and placed on lockdown in House 6A, which is used for Administrative Separation (ADSEP) and Disciplinary Isolation (DI) Lockdown. SDSD documentation showed Austin was provided a shower on 07-31-23 and 08-04-23. Detention Services Bureau (DSB) Policy & Procedure (P&P) Section L.11 Personal Hygiene, states that upon assignment to a housing unit an incarcerated person will be allowed a shower and additional showers at least every 48 hours thereafter. Furthermore, Title 15 states that 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. Absent exigent circumstances, no person shall be prohibited from showering at least every other day following assignment to a housing unit. If showering is prohibited, it must be approved by the facility manager or designee, and the reason(s) for prohibition shall be documented. SDSD documentation showed Austin was not provided with a shower within the 48-hour period, as mandated in policy. In addition, CLERB has noted this has been an ongoing issue in the detention facilities and will continue to strive towards making

changes by enforcing existing policy, making policy recommendations, and reporting these trends to the department. The evidence supports the allegation, and the act or conduct was not justified.

2. Misconduct/Procedure – Deputy 1 denied IP Austin medical treatment.

   Recommended Finding: Summary Dismissal
   Rationale: Austin stated that he has a medical condition that required weekly treatment and reported Deputy 1 failed to take him to his treatment, which caused him a lot of pain. DSB P&P Section M.1 Access to Care states that any incarcerated person in the custody of the San Diego Sheriff shall have quality and timely access to care for their medical, dental and mental health needs. SDSD jail medical records were reviewed and considered in the recommended findings. According to the Division Inspectional Services, Deputy 1 separated from the department on 01-18-24. CLERB rules state a summary dismissal may be appropriate if the subject officer is no longer employed by the Sheriff Department. The Review Board lacks jurisdiction.

3. Misconduct/Procedure – The San Diego Sheriff's Department (SDSD) did not provide pencil sharpeners to IPs.

   Recommended Finding: Action Justified
   Rationale: Austin complained that SDSD sells pencils but does not provide pencil sharpeners for IPs to use. A Departmental Information Source (DIS) stated there were not any pencil sharpeners available at that time, but IPs were provided with new, pre-sharpened golf pencils upon request. They also reported that IPs damage the pencil sharpeners to acquire steel parts to manufacture weapons and other contraband. Updated information was provided to CLERB on 05-30-24 that pencil sharpeners were available in all housing units. There was no evidence of a policy violation. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

4. Misconduct/Procedure – The SDSD provided IP's access to telephones with a "short cord."

   Recommended Finding: Action Justified
   Rationale: Austin complained that the cords on the telephones were "short." A Departmental Information Source (DIS) reported that the telephone cords are short to prevent IPs from hurting themselves and that the length of the telephone cord does not prevent the IPs from using the telephone. In accordance with Title 24, Minimum Standards for the design and construction of Local Detention Facilities Design requirements, "telephone cords shall be at a length that reduces the potential for use as a ligature." The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

5. Misconduct/Procedure – The SDSD delayed mail delivery.

   Recommended Finding: Action Justified
   Rationale: Austin complained that the "mail policy" at the detention facilities "violate federal and state laws" because the mail "shall be delivered the day of arrival." Austin reported when deputies pass out the mail, they stated that "mail isn't important." Title 15 Section 1063. Correspondence **does not** state that mail shall be delivered the same day of arrival. SDSD Detention Services Bureau Policy and Procedures (DSB P&P) states that all incoming non-legal mail will be routed to the Mail Processing Center (MPC) warehouse located at the Las Colinas Detention and Reentry Facility. Deputies assigned to the MPC and Sheriff's Transportation Detail (STD) will work collaboratively with detention facilities' staff to provide the **reasonably prompt delivery of incoming materials.** (**emphasis added**) Facility deputies will process and send out directly all outgoing correspondence. There are several protocols and reasons why mail would not be delivered in a "timely fashion," but it is not a violation of policy if and when mail is "not delivered the day of arrival." In addition, SDSD documentation showed that Austin had 3 books that were returned to sender due to inappropriate/prohibited content. The evidence showed the actions that occurred were lawful, justified and proper.

6. Misconduct/Procedure – The SDSD does not provide hot water for commissary items.

   Recommended Finding: Unfounded

Rationale: Austin stated, “Inmates are treated poorly,” and complained that they are provided with commissary items that need hot water or need to be heated. According to a Departmental Information Source, IPs have access to hot water for their commissary items, but no access to microwaves. In addition, DSB P&P Section K.1 Provision of a Nutritionally Adequate Diet states all incarcerated persons will be provided a diet which meets or exceeds Title 15 regulations. Commissary food items exceed the minimum requirements displayed in Title 15 Section 1241. Minimum Diet. The evidence showed that the alleged act or conduct did not occur.

23-118/KALISH (Inv. Klew)

1. Excessive Force – Probation Officers (POs) 1, 2 and 4 used force against the aggrieved at the Youth Transition Campus.

   Recommended Finding: Not Sustained.
   Rationale: The complainant, Sharon Kalish, alleged excessive force was used against the aggrieved while he was housed at the Youth Transition Campus (YTC). Kalish alleged that POs grabbed the aggrieved by his head and “smashed it down on the cement floor” and spread the aggrieved’s legs “apart as far as possible.” Kalish alleged the aggrieved sustained an injury as a result of the force used by POs in this incident. Documents received from the San Diego Probation Department (Probation), confirmed the aggrieved was in the custody of Probation at the East Mesa Juvenile Detention Facility (EMJDF) and that a use of force incident occurred. CCTV footage of the incident was provided, as well as involved PO reports. To gain further information about the actions of POs 1, 2 and 4, during the incident, Probation Employee Response Forms (PERFs) were sent to each PO. The confidential responses received in each of the PERFs were considered in the evaluation of this incident. Policies relevant to this use of force incident as follows: Probation Department Institutional Services Policy Manual (ISP) Section 514, Use of force, Subsection 514.3, Use of Force, stated, “Officers may use force as reasonably appears necessary in the performance of their duties, but excessive force shall not be used. Officers must use only that amount of force that appears reasonably necessary under the circumstances in order to gain control of the youth; protect and ensure the safety of youths, staff, and others; prevent serious property damage; prevent escape; obtain compliance with facility rules and staff orders; or ensure the institution’s security and good order, or for other lawful purposes. The Department provides tools, weapons, and training on techniques to use when responding to resistance and violent encounters. While various degrees of force exist, each officer is expected to use only that degree of force that is reasonable under the circumstances to successfully accomplish the legitimate and lawful purpose in accordance with this policy… Prior to resorting to the use of force, officers should, when practicable, attempt verbal persuasion, orders, or other tactics to avoid or mitigate the need for forceful action… Medical checks will be performed by a qualified health care professional on all youths who have been subjected to force as soon as practicable regardless of apparent injury. If no qualified health care professional is available, the youth shall be transported to the designated health care facility.” ISP Section 7.3.4.13, the Cover Command stated, “When youth hear the command, ‘COVER,’ they must immediately go to a kneeling position with their hands clasped behind their head, so their arms cover the side of the head and the face area… Officers use the ‘COVER’ command whenever there is a problem or emergency.” Considering ISP Subsection 514.3, Use of Force, as well as the involved POs incident reports, PERF responses, and CCTV footage, it is unclear whether or not the level of force used was appropriate. It should be noted, at this time, CLERB staff is unable to complete in-person interviews of POs subject to a CLERB investigation. In this case, testimony regarding the intricacies of what the involved POs observed, felt, and acted upon, would be critical in making a determination. This information is critical given use for force incidents should be evaluated without the benefit of hindsight, but rather by considering the totality of circumstances known at the time. At this time, the evidence that is available is insufficient to either justify or sustain against the actions taken by POs 1, 2 and 4. There was insufficient evidence to either prove or disprove the allegation.

2. Misconduct/Discourtesy – An unidentified PO used profanity towards the aggrieved.

   Recommended Finding: Not Sustained.
   Rationale: Kalish alleged that prior to the use of force incident an unidentified PO stated to the aggrieved, “I will do whatever the fuck I want to.” It should be noted, CCTV footage of this incident does not include an

audio recording. PERFs were sent to the POs present at the time of the use of force incident, and their confidential responses were considered for this allegation. At this juncture, there was insufficient evidence to either prove or disprove the allegation.

3. Misconduct/Intimidation – An unidentified PO stated "does it hurt yet" to the aggrieved, during the use of force incident.

   Recommended Finding: Not Sustained.
   Rationale: Kalish alleged that during the use of force incident, and unidentified PO "taunted" the aggrieved, stating, "does it hurt yet." See allegation #2. There was insufficient evidence to either prove or disprove the allegation.

4. Misconduct/Procedure – The Probation Department placed the aggrieved in "isolation" and he was "shackled for a week."

   Recommended Finding: Action Justified.
   Rationale: Kalish alleged that after the use of force incident the aggrieved was transferred from YTC to the East Mesa Juvenile Detention Facility (EMJDF), where he remained in "isolation and shackled for a week." Probation records showed the aggrieved was placed on Administrative Separation (A.S.) from 08-12-23 through 08-17-23. ISP Section 7.7.4, Administrative Separation (A.S.), provides guidelines for youth place on A.S. The policy stated, "A youth should be placed on Administrative Separation only when their actions have presented a security risk…" Additionally, the policy stated, "All AS youth shall be placed in waist chains and leg shackles every time they exit their room." Based on a review of the policy, and documents related to the allegation, no misconduct could be identified with classifying the aggrieved as A.S. and subsequently placing him in waist and leg chains when out of his room. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

5. Misconduct/Procedure – The Probation Department did not provide information, regarding the use of force incident to the mother of the aggrieved.

   Recommended Finding: Action Justified.
   Rationale: Kalish alleged she was informed the aggrieved was involved in a use of force incident, but that when she requested further information, or to speak with the aggrieved, the request was denied. ISP Section 514.6.2 Required Notifications, stated, "In addition to the notification of medical and mental health staff, the Division Chief or designee should ensure the parent or legal guardian of the youth is informed of any use of force, including the use of chemical agents." Probation documents showed that on 08-12-23, a Watch Commander called and spoke with Kalish and advised her the aggrieved was involved in a use of force incident and would be transferred to EMJDF. A follow up phone was made the same day which advised the aggrieved was transferred to EMJDF. Based on a review of the policy and documents provided by Probation, it appeared the notification requirement was met, and whether or not additional information was provided was not identified as misconduct. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

6. Misconduct/Medical – Unidentified Probation staff did not provide medical care to the aggrieved in a timely manner.

   Recommended Finding: Summary Dismissal.
   Rationale: Kalish alleged the aggrieved sustained an injury as a result of the force used. Kalish believes medical treatment was not provided to the aggrieved in a timely manner. As described in ISP Section 514.6.2, Required Notifications, medical and mental health staff should be notified after a use of force incident. Confidential medical records for the aggrieved were reviewed and considered when making a finding in this allegation. Based on a review of the documents, it appeared the requirements of custodial staff, as stated in ISP Section 514.6.2, were met. CLERB Rules and Regulations, Section 4, Authority, Jurisdiction, Duties and Responsibilities of CLERB, provides that "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…" Currently, CLERB does not have the authority to investigate

allegations involving medical staff at the Sheriff's Department or Probation Department. The Review Board lacks jurisdiction.

7. False Reporting – PO 3 wrote an "untrue" report about the use of force incident, which resulted in a "probation violation."

   Recommended Finding: Unfounded.
   Rationale: Kalish alleged that PO 3 wrote an untrue report of the use of force incident which ultimately resulted in the aggrieved returning to Court where it was determined the aggrieved violated his probation terms. The report referenced by Kalish was provided by Probation and was reviewed and considered when making a finding in this allegation. The report contained a synopsis of the use of force incident and appeared to be based on PO 4's Incident Report. It should be noted, PO 3 was not present during the use of force incident. It should also be noted, records received showed determination that the aggrieved had violated his probation terms was made by a Judge after hearing testimony of the POs involved. A review of PO 3's report did not reveal any misconduct. The evidence shows that the alleged act or conduct did not occur.

8. Misconduct/Procedure – PO 3 did not meet with the aggrieved for "55 days."

   Recommended Finding: Action Justified.
   Rationale: Kalish alleged that PO 3 was assigned to the aggrieved's case on 07-20-23 but did not meet with the aggrieved for a period of 55 days. Records showed the aggrieved was in a custodial setting at that time. Additional information was requested form Probation regarding this allegation. Probation advised that while a youth is in a custodial setting, there is not a specific policy which would require the assigned PO to meet with the youth. This is because while the youth is in custody, they are assigned a PO at the detentions facility who conduct regular face to face meetings with the youth. Documents provided by Probation showed the aggrieved had weekly face to face meetings with an assigned PO at EMJDF. A review of the associated documents showed PO 3 meeting or not meeting with the aggrieved, given the circumstance, is not misconduct. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

23-130/ATKINSON (Inv. Klew)

1. Misconduct/Procedure – Unidentified deputies did not review Atkinson's classification every seven days as required by policy.

   Recommended Finding: Unfounded.
   Rationale: On 11-07-23, CLERB received a signed complaint from Jeffrey Atkinson who alleged he was placed in Administrative Separation (Ad-Sep) at Vista Detention Facility and did not receive weekly classification reviews per policy. SDSD Detention Services Bureau – Manual of Policies and Procedures (DSB P&P) Section J.3, Separation: Definition and Use, defines Ad-Sep as "separate and secure housing, but shall not involve any other deprivation of privileges, other than is necessary to obtain the objective of protecting the incarcerated person, staff, or public." The policy stated, "JPMU will ensure the status of each separated person listed in sections II and III.D is reviewed at least every seven days… The seven-day review will be documented in JIMS. Comments will be entered into each person's JIMS history to describe the need for continued placement." Documents were received from SDSD which included custody and classification records associated with Atkinson. Ultimately, a review of the evidence showed that reviews of Atkinson's classification were conducted on a seven-day basis, in accordance with SDSD policy, and that Atkinson's allegation was unfounded. The evidence shows that the alleged act or conduct did not occur.

23-133/HARVEY (Inv. Klew)

1. Misconduct/Procedure – Unidentified deputies placed Incarcerated Person (IP) Harvey into a cell with another IP who assaulted him.

   Recommended Finding: Action Justified

Rationale: The complainant, Coasa Harvey, stated, "… I was placed in ad-seg in VDF pending Transfer… Deputies purposely placed me in a holding cell with another innate who attacked me…" According to SDSD documents related to this incident, Harvey was scheduled to be transferred out of Vista Detention Facility (VDF) after exhausting all housing options. It was determined Harvey would be transferred to SDCJ. SDSD Detention Services Bureau Policies and Procedures (DSB P&P) Section J.3, Separation: Definition and Use, defines both Administrative Separation and Protective Custody. The policy stated, Administrative Separation or Protective Custody "shall consist of separate and secure housing, but shall not involve any other deprivation of privileges, other than is necessary to obtain the objective of protecting the incarcerated person, staff, or public." It should be noted DSB P&P Section J.3 does not prevent Incarcerated Persons (IPs) classified as Protective Custody from being housed together. DSB P&P Section J.3 did state, "'Keep separate all' (KSA) is a housing status that further restricts housing options within P/C. Although KSA incarcerated persons are to be kept separate from other persons, they may be housed with other persons with similar KSA criteria." In this case, Harvey did not have a KSA classification prior to his placement in a holding cell with another IP. After a review of documents provided by SDSD, and the related P&Ps, no misconduct could be identified with Harvey's placement in a temporary holding cell with another IP with similar classifications. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

2. Misconduct/Procedure – Unidentified deputies delayed providing IP Harvey with his medication.

   Recommended Finding: Not Sustained
   Rationale: Harvey alleged that unidentified deputies made Harvey wait for "hours" after making a medical request. It should be noted that SDSD medical staff would be tasked with providing Harvey an inhaler. Confidential medical records were considered when making a finding in this allegation. SDSD provided incident reports which also contained confidential medical information. Ultimately, specific deputies, associated with this alleged misconduct, were not identified, and there was an overall lack of evidence. There was insufficient evidence to either prove or disprove the allegation.

3. Misconduct/Procedure – Unidentified deputies "ignored" IP Harvey's intercom button.

   Recommended Finding: Not Sustained
   Rationale: Regarding Harvey's allegation that unidentified deputies "ignored" his intercom requests, there is a lack of evidence. SDSD does not maintain a record of individual intercom requests. DSB P&P Section I.2, Intercom Systems, stated, "Intercoms are generally located in areas accessible by incarcerated persons (e.g., dayrooms, cells, classrooms, etc.). Each facility shall maintain an intercom system to be utilized by incarcerated persons for the purpose of providing a means of communication between sworn staff and incarcerated persons. Intercom systems should be primarily used as a means of relaying and or summoning emergency assistance. Intercoms shall not be routinely muted or silenced." Additionally, the policy stated, "In the event an intercom is silenced or muted, sworn staff must make an entry in the Area Activity log, utilizing the "ALARMS" drop-down in the Jail Information Management System (JIMS). At a minimum, the description field must include the cell number or the incarcerated person's name and booking number." A review of the Area Activity Log did not indicate any misconduct occurred. There was insufficient evidence to either prove or disprove the allegation.

4. Misconduct/Procedure – Unidentified deputies "denied" IP Harvey regular access clean clothes, a shower, and the dayroom.

   Recommended Finding: Not Sustained
   Rationale: Harvey alleged unidentified deputies "denied" Harvey regular access to clean clothes, a shower, and the dayroom. Regarding distribution of laundry, DSB P&P Section L.1, Laundry Schedule, stated, "Incarcerated population's bedding, linen and clothing shall be exchanged according to established facility schedules. Each facility will develop laundry procedures and a facility green sheet for the exchange of laundry." The "Green Sheet" for SDCJ regarding laundry exchange stated, "Housing Floor Deputies will gather the necessary clothing and linen for incarcerated persons housed in 4F. At the conclusion of laundry exchange for the other modules, deputies will perform laundry exchange in this unit without the use of facility workers." A review of Harvey's housing placement showed he was not housed in "4F." An incident report dated 10-14-23 did state that Harvey submitted a grievance from stating he was not provided laundry during

the scheduled exchange time. The incident report stated a deputy provided Harvey with clean laundry in response to the grievance. No other evidence could be identified which showed Harvey was not provided with laundry. Additionally, there was no evidence identified which showed Harvey was denied access to shower or regularly scheduled meal(s). There was insufficient evidence to either prove or disprove the allegation.

5. Misconduct/Procedure – Unidentified deputies "withheld and/or denied" IP Harvey his mail.

   Recommended Finding: Not Sustained
   Rationale: Harvey alleged that his mail was being withheld and/or denied. SDSD DSB Section P.3, Incarcerated Person Mail, established guidelines for the processing of mail for IPs. The policy stated in part, "There shall be no limit on the amount of mail an incarcerated person may send, and no limit on the amount of mail that they may receive, except to the extent that possession of such materials may constitute a fire hazard or pose an unacceptable security risk by providing the means to hide contraband. All incoming non-legal mail will be routed to the Mail Processing Center (MPC) warehouse located at the Las Colinas Detention and Reentry Facility." Regarding mail that is rejected, the policy stated, "In cases in which incoming mail is withheld for reasons other than drugs/narcotics items: 1. The MPC deputies will enter a "MREJ" event type into the receiving incarcerated person's JIMS history." A review of the associated records did not show any entries titled "MREJ" for the complainant. Overall, there was a lack of evidence associated with this allegation and insufficient evidence to either prove or disprove the allegation.

6. Misconduct/Procedure – Unidentified deputies "denied" IP Harvey video visits.

   Recommended Finding: Unfounded
   Rationale: Harvey alleged that he was denied video visitation while in custody. A review of associated evidence did not support Harvey's allegation. DSB P&P Section P.9, Social Visiting, established guidelines for permitting IPs social visits. Documents received from SDSD disputed Harvey's allegation. The evidence shows that the alleged act or conduct did not occur.

7. Misconduct/Procedure – Unidentified deputies gave "special treatment" to another IP.

   Recommended Finding: Not Sustained
   Rationale: Harvey alleged that "IP [redacted]" was given special treatment with regard to access to the dayroom. It should be noted, no specific deputies were identified with this allegation. Documents regarding Harvey's classification and access to the dayroom were reviewed. Given that IPs have varying classifications, and that no misconduct could be identified with Harvey's access to the dayroom, it could not be determined that another IP was given special treatment. There was insufficient evidence to either prove or disprove the allegation.

23-140/CARMAGO (Inv. Klew)

1. Misconduct/Procedure – Unidentified Probation Officers (POs) failed to intervene when the aggrieved was assaulted.

   Recommended Finding: Unfounded
   Rationale: On 11-02-23, CLERB received a signed complaint from Patricia Camargo, Aunt of the aggrieved, a juvenile in the custody of the Probation Department. Additionally, on 11-09-23, CLERB received an additional signed complaint from Veronica Camargo, mother of the aggrieved. In both complaints, it is alleged that the aggrieved, who, at the time of the alleged incidents, was housed at East Mesa Juvenile Detention Facility (EMJDF), was being target by other juveniles in the facility, and that EMJDF staff were not intervening to stop the assaults from other youth. The Probation Department provided Incident Reports as well as Contact Logs associated with the aggrieved. The Incident Reports reviewed showed that on 10-22-23, 10-24-23, 11-01-23, and 11-03-23, the aggrieved was involved in physical altercations with other youth housed at EMJDF. Probation Department Institutional Services Policy (ISP) Manual Section 514, Use of Force, established guidelines for the application of force, as well as responsibilities and reporting requirements. ISP Manual Section 514.3, Use of Force, stated in part, "Medical checks will be performed by a qualified health

care professional on all youths who have been subjected to force as soon as practicable regardless of apparent injury." ISP Manual Section 514.5, Immediate and Calculated Use of Force, stated in part, "An immediate use of force occurs when force is used to respond without delay to a situation or circumstance that constitutes an imminent threat to security or safety. For example, the immediate or unplanned use of force by staff may be necessary to stop a youth from inflicting life-threatening self-injuries or to stop an assault on any other person, including other youths." ISP Manual Section 514.6.2, Required Notifications, stated in part, "In addition to the notification of medical and mental health staff, the Division Chief or designee should ensure the parent or legal guardian of the youth is informed of any use of force, including the use of chemical agents." A review of the Incident Reports indicated that staff intervention was required to stop the physical altercations occurring. Each incident occurred when numerous youths were out of their rooms, such as meal or recreations times, and that staff acted in a timely manner when the incidents occurred. A review of the Incident Reports showed that medical care was provided, and parents were contacted, after each incident, pursuant to Probation Policy. A review of the documents provided did not show any misconduct on behalf of the involved Probation Officers. The evidence shows that the alleged act or conduct did not occur.

23-150/SYKES (Inv. Klew)

1. Misconduct/Procedure – Deputy 1 cited the aggrieved for a violation of the CA Penal Code.

   Recommended Finding: Action Justified
   Rationale: Included in her complaint to CLERB, Complainant Sykes alleged that Deputy 1 targeted the aggrieved, and three other students at a high school, and cited them for violation of CA PC Section 415, Disturbing the Peace. Evidence reviewed in this case included Deputy 1's report and Body Worn Camera (BWC) footage of the incident. Ultimately, a review of Deputy 1's report, as well the BWC footage, did not show any misconduct occurred. SDSD P&P Section 2.1, stated, "All employees shall conform to Federal, State, and Local laws, as well as to the policies of this Department. It shall be the responsibility of all employees to familiarize themselves and comply with all such policies, orders, directives, rules and regulations of this Department." Additionally, SDSD P&P Section 2.30, Failure to Meet Standards, stated in part, "Employees shall properly perform their duties and assume the responsibilities of their positions. Employees shall perform their duties in a manner which will tend to establish and maintain the highest standards of efficiency in carrying out the mission, functions, and objectives of this Department." There was no misconduct associated with Deputy 1 conducting an official law enforcement duty. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

23-153/ ROSENTHAL (Inv. Bohan)

1. Misconduct/Procedure – Detention deputies "locked" Troy Rosenthal in administrative separation.

   Recommended Finding: Action Justified
   Rationale: Rosenthal stated, "I am a civil detainee, SVP [sexually violent predator], who has been locked in administrative segregation for 10 months because originally I yelled at someone for waking up my entire module. Per the SVP law my housing is supposed to be less restrictive and not punishment than criminal detainees." According to San Diego Sheriff Department (SDSD) Detention's Policy R.5 Housing of Sexually Violent Predators (SVP), Individuals committed to the custody of the Sheriff under this act are civil commitments. They will be confined in a manner that maintains jail security and allows for the effective management of the facility. SVPs will be housed separately from all other inmates, but they may be housed together with other SVPs. Records documented numerous incidents of Rosenthal's failure to meet the minimum jail standards as those required of all SVP's. Due to Rosenthal's threatening behavior toward other SVP's and staff, instigating fights, talking openly on the phone about other SVP's, as well as his disregard of the rules, his placement in separate housing was appropriate and in compliance with Detention policies. The policy R.5 addresses civil commits inability to conform to the rules and allows for the placement into separate housing when they fail to comply and demonstrate an ongoing inability to comply. Additionally, per Detention Policy J.3, Separation: Definition and Use, Those who have displayed a continual failure to adjust and conform to the minimum standards expected of those in designated special housing and who's behavior is disruptive to the safe operation of the facility may be placed into administrative separation. The evidence showed that the alleged act or conduct did occur and was lawful, justified and proper.

2. Misconduct/Procedure – Deputy 1 denied Rosenthal's request for a housing change.

   Recommended Finding: Action Justified
   Rationale: Rosenthal stated, "I would like to go back to the module for SVP's only Deputy 1 keeps saying no." Rosenthal was afforded the opportunity to return to the SVP module with the expectation of maintaining and he was informed that if he caused issues again, he would return to separate housing. Although Rosenthal stated he understood and would maintain in the module he continued to demonstrate the same behavior and was placed back into separate housing. According to his documented history, Rosenthal exhausted the housing options for SVP's and the policy is clear in that all SVP's will be housed separate from the general population and if unable to abide by SVP module rules will be housed alone in administrative separation. The evidence showed that Rosenthal's placement in separate housing was justified and in compliance with policy.

SUMMARY DISMISSAL (0)

End of Report