County of San Diego

CITIZENS' LAW ENFORCEMENT REVIEW BOARD

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The Citizens' Law Enforcement Review Board made the following findings in the closed session portion of its August 13, 2024, meeting held in person. **Any changes or additions to staff's recommended findings are bolded in red.** Minutes of the open session portion of this meeting will be available following the Review Board's review and adoption of the minutes at its next meeting. Meeting agendas, minutes, and other information about the Review Board are available upon request or at www.sdcounty.ca.gov/clerb.

CLOSED SESSION

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

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

CASES FOR SUMMARY HEARING (11)

ALLEGATIONS, BOARD FINDINGS & RATIONALES

DEATH INVESTIGATIONS (3)

22-021/LI (Inv. Klew)

1. Death Investigation/Officer Involved Shooting – San Diego Sheriff's Department (SDSD) Deputies Javier Medina and David Williams discharged their firearms resulting in the death of Yan Li on 03-03-22.

   Board Finding: Action Justified
   Rationale: CLERB Rules and Regulations, Section 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents, states, "CLERB shall have authority to review, investigate, and report on the following categories of incidents, regardless of whether a Complaint has been filed… The death of any individual arising out of or in connection with actions of peace officers or custodial officers employed by the County in the Sheriff's Department or the Probation Department, arising out of the performance of official duties." Evidence received from SDSD, which included numerous reports, photos, and body worn camera footage (BWC), showed that on 03-03-22, a SDSD deputy attempted to serve Yan Li with a Writ of Possession at her residence. BWC footage of the initial interaction with Li was available to review. When the deputy tried to serve the Writ to Li, she opened the door with a "meat cleaver" in her hand. The deputy was able to hand the Writ to Li, however, Li refused to comply with the deputy's commands to drop the knife, dropped the eviction notice to the floor, and closed the door. During the interaction, Li made comments that she did not believe the deputy was a "real" peace officer and she appeared to be in an agitated mental state. The initial

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deputy subsequently called for backup. SDSD personnel arrived, which included Deputy 3, Deputy Williams, and Deputy Medina as well as numerous San Diego Police Department (SDPD) personnel. The responding law enforcement personnel learned that the day before, or a couple of days before, Li had threatened condominium personnel and maintenance workers with a knife when they entered her residence to fix a water leak. According to a SDSD Crime/Incident Report, the general manager and building engineer of the Condominium Li was residing reported that on 03-02-22 they went inside Li's apartment for a plumbing issue and that Li came out of her bedroom and charged at them with a knife in her hand. Based upon the statement of two employees, SDSD personnel determined that Li's conduct was in violation of CA Penal Code (PC) Section 245(a), assault with a deadly weapon. The law enforcement personnel decided that they could not just walk away from the incident, because they were concerned that based upon Li's conduct towards the initial deputy, and her reaction to the building staff, that she could attack residents of the building, or other uninvolved people. Evidence showed that while a plan to arrest Li was being discussed, SDSD personnel attempted to communicate with Li to gain her compliance, through the door to her apartment, unsuccessfully. Evidence also showed law enforcement personnel requested a Psychiatric Emergency Response Team (PERT) history check on Li but did not receive any relevant information. Law enforcement personnel ultimately entered Li's apartment utilizing numerous less than lethal force options, including a bean bag gun, a pepper ball gun, and a SDPD K-9, in an attempt to arrest Li for the alleged violation of PC Section 245(a). As the SDSD personnel entered Li's apartment, Li was ordered to show her hands and to come out with her hands up. Li came out of a room but did not comply with the directives to drop the knife. A Deputy fired multiple bean bags at Li and moved closer to her as while other deputies also entered the apartment. The bean bags appeared to not have an effect on Li. The SDPD Officer with his K-9 were asked to assist, however, as the officer entered the apartment, Li quickly advanced towards the law enforcement personnel with knife in hand. The law enforcement personnel attempted back out of the apartment; however, they were unable to exit quickly enough, and Li was able to stab the SDPD K-9 Officer, who subsequently fell to the ground along with Deputy [Redacted]. Deputies Williams, J. Medina, and 3, and an SDPD Officer, consequently discharged their firearms at Li, in defense of themselves and the other law enforcement officers present. Life saving measures were taken by the law enforcement personnel present and a medical response was requested. Li did not survive her injuries. On 03-04-22, SDMEO Deputy Medical Examiner Paige Peterson, M.D., conducted an autopsy of Li at the SDMEO. The cause of death was multiple gunshot wounds, and the manner of death homicide. Toxicology testing of blood specimens was negative for alcohol or common drugs of abuse. SDSD P&P Addendum Section F, Use of Force Guidelines, regarding the use of deadly force stated, "Deputies may only use lethal force when they reasonably believe, based on the totality of the circumstances, that lethal force is necessary to defend against an imminent threat of death or serious injury to the deputy or to another person; or to apprehend a fleeing person for any felony that threatened or resulted in death or serious bodily injury, if the deputy reasonably believes that the person will cause death or serious bodily injury to another unless immediately apprehended." Additionally Penal Code Section 835a provides a legal standard regarding the use of force, and stated, "That the decision by a peace officer to use force shall be evaluated from the perspective of a reasonable officer in the same situation, based on the totality of the circumstances known to or perceived by the officer at the time, rather than with the benefit of hindsight, and that the totality of the circumstances shall account for occasions when officers may be forced to make quick judgments about using force." Regarding the use the bean bag and pepper ball guns, Addendum Section F, classified these as "Specialty munitions are projectiles used as intermediate force options, force capable of inflicting significant pain and causing serious injury but force less severe than lethal force. Generally, it is the intent of law enforcement to use this type of specialty munition to increase the chances of not having to use lethal force. When used properly, by trained personnel, this type of specialty munition is less likely to result in death or serious injury." When considering the actual force used, the evidence was clear that Deputies Williams, J. Medina, and 3, and the SDPD Officer, reasonably believed there was an imminent threat of death or serious bodily injury to themselves and others present. This was evidenced through Li's actions of advancing towards them with a knife and stabbing an SDPD officer. As such, the decision to discharge their firearms in defense of themselves and others was justified.

2. Death Investigation/Officer Involved Shooting – SDSD Deputy 3, and a San Diego Police Department (SDPD) Officer, discharged their firearms resulting in the death of Yan Li.

   Board Finding: Summary Dismissal

Rationale: See Rationale #1. Pursuant to CLERB Rules and Regulation, Section 4.3, CLERB only has jurisdiction of peace officers employed by the Sheriff's Department or the Probation Department. As such, CLERB does not have jurisdiction to make findings related to the actions of the SDPD Officer involved in this incident. Additionally, SDSD advised that Deputy 3 has retired prior to the completion of CLERB's investigation. The Review Board lacks jurisdiction.

3. Illegal Search & Seizure – SDSD Deputy 1 approved entry into Li's residence without a search warrant.

   Board Finding: Summary Dismissal
   Rationale: Per the countywide Memorandum of Understanding (MOU), critical incidents involving SDSD deputies will be investigated by SDPD. Once SDPD completed their investigation, it was sent to the District Attorney's Office (D.A.) for review. According to the D.A.'s 27-page evaluation of this incident, "The ultimate question in this inquiry is whether those involved bear criminal liability for their actions…" Also noted in the D.A.'s evaluation of this incident, "Consideration was also given to the fact that a search warrant was not sought. The law is clear that regardless of whether a search warrant was obtained a person may not use a weapon to attack or assault peace officers even if the peace officers may not be acting within the scope of their duties." The Fourth Amendment to the United States Constitution generally requires that a law enforcement officer obtain a judicial warrant before entering a home without permission. SDSD P&P Section 6.116, Search Warrant Service, stated, "All Sheriff's Department employees shall execute search warrants, parole and 4th waiver searches according to established rules of law and shall not willfully violate the constitutional rights of citizens." As such, a legal opinion was sought regarding the legality of entering Li's apartment without a search warrant. Applicable law, Lange v. California (2021) 594 U.S. ___; 141 S. Ct. 2011, 2013, citing Riley v. California (2014) 573 U.S. 373, 382, and Fisher v. City of San Jose (9th Cir. 2009) 558 F.3d 1069, 1075 (en banc), noted that "…an officer may make a warrantless entry when 'the exigencies of the situation,' considered in a case specific way, create 'a compelling need for official action and no time to secure a warrant.'" Additionally, "exigent circumstances are defined to include 'those circumstances that would cause a reasonable person to believe that entry…was necessary to prevent physical harm to the officers or to other persons, the destruction of relevant evidence, the escape of the suspect, or some other consequence improperly frustrating legitimate law enforcement efforts.'" In this case, the law enforcement personnel present believed they could not simply walk away from Li's residence, given the circumstances. Ultimately, the legal opinion submitted determined that the deputies had exigent circumstances sufficient to enter Li's condominium without a warrant. It should be noted, Deputy 1 has since retired from the SDSD and the Review Board lacks jurisdiction.

4. Misconduct/Procedure – SDSD deputies failed to utilize de-escalation techniques.

   Board Finding: Unfounded
   Rationale: This investigation also reviewed the actions taken by SDSD prior to the shooting, including examining what attempts were made for de-escalation as per SDSD P&P. Addendum Section F, regarding de-escalation, stated, "De-escalation is defined as actions taken in an attempt to stabilize an incident in order to try and reduce the immediacy of a threat by obtaining more time, tactical options or resources to resolve an incident. The 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, crisis intervention tactics and alternatives to force techniques shall be used when it is safe and feasible to do so. De-escalation does not require that a deputy risk their safety or the safety of the public." Additionally, the policy stated, "If time and circumstances reasonably permit, deputies should consider whether a subject's lack of compliance is a deliberate attempt to resist being taken into custody or rather an inability to comply with deputy orders based on factors including, but not limited to… psychological or emotional crisis. A deputy's assessment of these factors, when time and circumstances reasonably permit, should be considered when deciding which tactical options to potentially use to attempt to bring the incident to the safest possible resolution." The also cited that requesting additional resources, such as the Psychiatric Emergency Response Team (PERT), may be considered. SDSD P&P Section 6.113 Psychiatric Emergency Response Team (PERT), stated, "The Sheriff's Department is committed to providing a regional mobile response to the crisis needs of the mentally ill. The Sheriff's Department will participate in a multi-disciplinary partnership to provide regional crisis mobile response for the mentally ill. This partnership will be identified as the Psychiatric Emergency

Response Team (PERT). The PERT teams provide the most humane and appropriate dispositions for mentally disordered persons who have come to the attention of law enforcement. PERT teams will respond to any patrol units request for assistance when the unit is handling the mentally ill or individuals in crisis. PERT personnel will assess the situation, evaluate the individual(s) in question, and as appropriate, make referral(s) to community-based resources or treatment facilities." It was apparent the deputies present took preparations to obtain "less-lethal" intermediate force options, by considering the use of the bean bag and pepper ball guns. It was also apparent that deputies felt there was a need to enter Li's apartment to place her under arrest for the alleged violation of PC Section 245(a). Documents also showed that no relevant information was returned via a PERT history check. Again, what was reflected in the interviews of the law enforcement personnel present is that the mindset was there was a risk to the community given Li's actions. SDPD conducted witness statements of numerous residents of the apartment building in which Li resided. Several individuals noted their belief that Li was "mentally ill" and had described previous incidents of Li's unusual behavior. This information may not have been known to the deputies present at the time. However, based on Li's behavior while they were there, it was reasonable to conclude that Li was experiencing a mental health crisis. This was evidenced through Li's comments that the deputies present were "intruders" or "imposters" and through her erratic behavior. It should also be noted that this use of force incident, as instructed by law, should be evaluated without the benefit of hindsight, and through the eyes of law enforcement personnel present at that time. It is important to reiterate SDSD's policy regarding de-escalation, that "De-escalation, crisis intervention tactics and alternatives to force techniques shall be used when it is safe and feasible to do so." The law enforcement personnel present were in a position to safely continue efforts to de-escalate, to potentially avoid a use of force incident. In this case, tragically, the use of force resulted in the death of Li. However, the evidence also showed that attempts were made to de-escalate. Law enforcement personnel staged outside of Li's residence, attempted to communicate with her, and obtained intermediate force options including a SDPD K-9. The decision to then enter Li's apartment to arrest her for the alleged violation of PC Section 245(a) does not constitute a policy violation. The evidence shows that the alleged act or conduct did not occur.

22-057/NUGENT (Inv. Wigfall)

1. Death Investigation/Suicide – Deputies 1 - 3 attempted to serve Robert Nugent with an eviction notice on 05-06-22.

   Board Finding: Action Justified
   Rationale: Robert Nugent was a 56-year-old White male that resided in El Cajon. According to SDSD documentation, on 05-06-22, Deputies 1-3 arrived at Nugent's residence to serve a court ordered eviction to Robert Nugent. Nugent's sibling and the plaintiff in the court order, was also present. Deputy 3 approached the front door, knocked several times and yelled, "Sheriff's Department, court ordered eviction, come to the door." Deputies reported they "waited ample time for the tenant to come to the door" before requesting a locksmith to drill out the lock. Deputy 2 proceeded to knock on the door when another deputy reported he heard a noise from inside the house and noticed fire. He warned the other deputies, and they took cover and called for reinforcements. Deputies heard glass breaking and saw the house become quickly engulfed in flames. After the fire was extinguished, the Sheriff's Bomb/Arson unit arrived and found evidence of an accelerant and Nugent lifeless in the bathroom. On 05-09-22, the San Diego Medical Examiner's Office conducted an autopsy of Nugent and determined the cause of death was thermal injuries with smoke inhalation and the manner of death was suicide. A toxicology report showed Nugent's blood was presumptive positive for amphetamines, and methamphetamines. Court Services Bureau Policies & Procedure (DSB P&P) states that the Sheriff shall serve all process and notices in the manner prescribed by law. Policy section D.3 Filed Services: Orders for Forthwith Removal (OFR) states at the time of execution of the process, if the defendant refuses to comply or to allow the deputies to enter, a forcible entry may be made if (A) Probable cause exists to believe the subject of the removal order is inside and (B) the requirements of "knock and notice", per 844 PC, have been complied with. Search and Seizure/forcible entry of premises states that is the "knock and notice" requirements are met, officers may legally break in or force their way into premises to make an arrest. Although deputies did not make entry into the home, they used a locksmith to remove the lock from the door for entry. BWC showed that Deputy 3 knocked on the door, announced themselves as the Sheriff's Department and stated their purpose, per PC 844, Breaking into House to Arrest.

Deputies also provided confidential statements that supported the recommended finding. There were no policy violations found and the evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

2. Death Investigation/Suicide – Deputy 4 attempted to serve Robert Nugent with an eviction notice on 05-06-22.

   Board Finding: Summary Dismissal
   Rationale: See Rationale #1. According to the Division of Inspectional Services, Deputy 4 is no longer employed by the Sheriff's Department. Per CLERB Rules and Regulations, Section 15, when a subject officer is no longer employed by the Sheriff's Department, a Summary Dismissal may be appropriate. The Review Board lacks jurisdiction, or the complaint clearly lacks merit.

23-068/ORNELAS JR. (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.

   Board 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.

   Board 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.

   Board 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.

   Board 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."

   Board 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.

   Board Finding: Unfounded
   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. At the request of the Board, Deputy 1, as well as the investigating homicide detectives, were served with and responded to multiple Sheriff's Employee Response Form (SERF) and provided confidential information that was considered in arriving at the recommended finding. That information is privileged 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 so as to not be solely dependent on department issued equipment. The additional evidence showed that the alleged act or conduct did not occur.

USES OF FORCE RESULTING IN GREAT BODILY INJURY (0)

PRIORITY (1)

23-112/LEVELL (Inv. Klew)

1. Misconduct/Procedure – Detention deputies rehoused Jordan Levell in a module with his alleged "assailant."

   Board Finding: Not Sustained
   Rationale: The complainant, Jordan Levell, alleged he was rehoused in a module with his alleged "assailant." According to SDSD P&P 6.127 titled "Prison Rape Elimination Act (PREA) Procedure," when staff learns that an inmate is subject to substantial risk of imminent sexual misconduct, immediate action will be taken to protect the inmate. Sworn first responders learning of an allegation that a detainee/inmate was sexual abused shall separate the alleged victim and abuser. The procedure also states, "the Department shall employ multiple protection measures, such as housing changes or facility changes." Furthermore, SDSD DSB P&P F.16 titled "Sexual Misconduct Case Assignment & Investigations", states when responding to sexual abuse between incarcerated individuals, to "secure the safety of the victim away from the suspect." Levell's Inmate History Summary report indicated following discharge from Enhanced Observation Housing (EOH) on 09-15-23, he was moved to facility 3, area 6, housing unit A, cell 101, bed B. The next entry on his inmate history summary report was "BADM" indicating a bad move. It was indicated "enemy exists in new housing location." The next move did not occur until 09-19-23 in which Levell was transferred to Vista Detention Facility (VDF). [Redacted]'s Inmate History Summary Report indicated he remained housed in Area 6, Housing Unit A when Levell was discharged from EOH. SDSD records showed a keep separate from [Redacted] was added to Levell's classification records on 09-14-23. The evidence showed although they were housed in the same module, they were not granted dayroom/phone, or shower use at the same time. It is unclear whether this would violate PREA or SDSD P&P related to PREA. There was insufficient evidence to either prove or disprove the allegation.

2. Misconduct/Procedure – Deputy 1 disclosed confidential information.

   Board Finding: Not Sustained
   Rationale: According to Levell, Deputy 1 told Levell's cellmate that Levell filed a report after he was told he would remain confidential. SDSD P&P 6.127 titled "Prison Rape Elimination Act", states "The Department shall comply with The Prison Rape Elimination Act (PREA) of 2003 by establishing a zero-tolerance standard for all forms of Sexual misconduct in detention facilities, patrol station lockups, holding cells or courthouses." PREA policy states the agency shall provide multiple internal ways for inmates to privately report sexual abuse and sexual harassment. The policy also states they shall provide at least one way for inmates to report abuse or harassment to a public or private entity and allow the inmate (IP) to remain anonymous upon request. Levell stated, "Deputy 1 stated while doing his initial assessment and taking my statement that what I said would be confidential due to my rights under the PREA Act". Levell stated, Deputy 1 pulled his cellmate "to the phones a couple feet away and said he shouldn't talk to me due to the investigation and not to worry my case was bullshit." SDSD DSB P&P F.16 titled "Sexual Misconduct Case Assignments and Investigations", states "California Penal Code 293(a): Any employee of a law enforcement agency who personally receives a report from any person, alleging that they have been the victim of a sex offense, shall inform that person that his or her name will become a matter of public record unless he or she requests that it not become a matter of public record, pursuant to Section 6254 of the Government Code. When a victim of a sexual abuse requests their name be confidential, the deputy will fill out the victim

information on the report. The very first sentence, above the synopsis, should be bold typed and contain the sentence, “THE VICTIM IN THIS REPORT REQUESTS TO REMAIN CONFIDENTIAL PURSUANT TO CALIFORNIA PENAL CODE 293(a) AND CALIFORNIA GOVERNMENT CODE 6254." SDSD records showed the first sentence of the report indicated Levell requested to remain confidential pursuant to penal code 293(a). Deputy 1 provided confidential information during CLERB’s investigation that cannot be publicly disclosed and was considered in arriving at the recommended finding. Based on the lack of audio evidence, there was insufficient evidence to determine if a policy violation occurred.

3. Misconduct/Discourtesy – Deputy 1 discredited Levell.

   Board Finding: Not Sustained
   Rationale: Levell stated, “Deputy 1 an investigating detective made statements to the cellmate that Jordan was ‘crazy’ and allegations were ‘bullshit’.” See Rationale #4. Deputy 1 provided confidential information during CLERB’s investigation that was considered in arriving at the recommended finding. Based on the lack of audio evidence, there was insufficient evidence to determine if this occurred.

4. Misconduct/Discourtesy – Deputy 3 discredited Levell.

   Board Finding: Unfounded
   Rationale: Levell stated, “Deputy 1 an investigating detective made statements to the cellmate that [Jordan] was “crazy”, and allegations were “bullshit’.” SDSD records showed Deputy 3 investigated the incident. SDSD produced audio recordings of Deputy 3’s interview with [Redacted]. The audio recordings showed [Redacted] stated the statements were “bullshit.” The evidence showed Deputy 3 did not state Jordan was “crazy” nor that the allegations were “bullshit”. The evidence showed that the alleged act or conduct did not occur.

5. Misconduct/Procedure – SDSD failed to perform an examination(s) pursuant to PREA.

   Board Finding: Action Justified
   Rationale: Levell alleged he reported to detention deputies information related to PREA and that an examination did not occur. According to PREA 115.21, “the agency shall offer all victims of sexual abuse access to forensic medical examinations, whether on-site or at an outside facility, without financial cost, where evidentiarily or medically appropriate. Such examinations shall be performed by Sexual Assault Forensic Examiners (SAFEs) or Sexual Assault Nurse Examiners (SANEs) where possible. If SAFEs or SANEs cannot be made available, the examination can be performed by other qualified medical practitioners. The agency shall document its efforts to provide SAFEs or SANEs.” SDSD records showed a follow-up investigation was performed by the Detentions Investigations Unit (DIU) on 09-14-23. Confidential personal health information was considered in making this finding. Additionally, SDSD’s investigation, which contains confidential personal health information was also considered. SDSD P&P 6.127 procedures states to notify facility medical staff for a Sexual Assault Response Team (SART) exam if the alleged sexual abuse is reported or discovered prior to 120 hours after the incident. This information aligns with SDSD DSB P&P Policy F which states to preserve evidence if the incident occurred within 120 hours. The “Sexual Abuse Checklist” within the policy states, “If the incident occurred longer than 120 hours and there is no obtainable evidence (fluids etc.) simply document the facts of the case and actions of the deputy.” Based upon the evidence reviewed, it was appropriate a SAFE or SANE exam was not performed. The evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

6. Misconduct/Discourtesy – Deputy 2 used profanity towards Levell.

   Board Finding: Not Sustained
   Rationale: Levell stated “Deputy 2 said what you little bitch in an aggressive tone and without trying to de-escalate the situation or get a pencil he immediately went to kick my tray slot closed with his foot and his knee and hand causing my arm to bleed.” According to an Incident Report, Deputy 2 stated while providing security for medication pass, Levell attempted to reach outside the handcuffing portal toward his jail keys and yelled, “I don’t want my meds.” Deputy 2 pulled his keys away and pushed the handcuffing portal down

with his right knee and secured the lock with his jail issued key. Deputy 2 noted as a result Levell was escorted to medical where he was evaluated and treated. Confidential SDSD Jail Medical records were considered in making this finding. Jail CCTV footage was reviewed, and a deputy and nurse can be seen during medication pass outside of Levell's cell, however due to poor video quality and distance from camera, CLERB was unable to verify what occurred. Based on lack of evidence and credible witnesses, CLERB was unable to determine what occurred. There was insufficient evidence to either prove or disprove the allegation.

7. Misconduct/Procedure – Deputy 2 failed to use de-escalation technique(s).

   Board Finding: Not Sustained
   Rationale: See Rationale #6. There was insufficient evidence to either prove or disprove the allegation.

8. Excessive Force – Deputy 2 "assaulted" Levell.

   Board Finding: Not Sustained
   Rationale: See Rationale #6. There was insufficient evidence to either prove or disprove the allegation.

ROUTINE (7)

23-092/BRINK (Inv. Aldridge)

1. Misconduct/Procedure – The San Diego Sheriff's Department (SDSD) failed to protect Incarcerated Person Jeremy Brink from contracting COVID-19 during his incarceration.

   Board Finding: Not Sustained
   Rationale: In Brink's letter to CLERB, he claimed to have contracted COVID-19 during his incarceration. According to the Center of Disease Control and Prevention website, referenced from the National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases, symptoms for COVID-19 may appear 2-14 days after exposure to the virus. Brink had been incarcerated for 13 days before he began to feel symptomatic. In review of the SDSD's COVID-19 documents, the SDSD took the following preventive measures in their attempts to prevent the spread of COVID-19 and to ensure the health and safety of incarcerated persons. All incarcerated persons presenting symptoms of COVID-19, or other respiratory illnesses, were tested. If there are positive results, incarcerated persons were quarantined and placed in respiratory isolation housing units. CLERB was unable to confirm Brink contracted COVID-19 while he was in the custody of the SDSD, nor that the SDSD was negligent in its attempts to prevent the spread of COVID-19 within the jail, specifically the VDF. In review of the records that were available, CLERB found that the SDSD was not negligent in recognizing and addressing the known health risks within the facility and took appropriate steps in their attempt to prevent the spread of COVID-19 with the jails. Brink's jail medical records were obtained and reviewed; however, that information cannot be disclosed due to the Health Insurance Portability and Accountability Act (HIPPA) which protects the individual's sensitive health information. There was insufficient evidence to either prove or disprove the allegation that Brink contracted COVID-19 during his incarceration, or that the San Diego Sheriff's Department (SDSD) failed to protect Brink from contracted COVID-19 while he was in their custody.

2. Misconduct/Medical – Jail medical/health staff failed to respond to Brink's medical request.

   Board Finding: Summary Dismissal
   Rationale: Brink alleged that he submitted two medical sick call requests, but neither request was responded to. Brink said, "*...I put in two more request for medical. Both went unanswered*." The purpose of SDSD Detention Services Bureau (DSB) Manual of Policies and Procedures (P&P) Section M.1 titled "Access to Care," was to establish guidelines for reasonably prompt access to medical services for any incarcerated person complaining of illness or injury. 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.15 titled "Sick Call," incarcerated persons shall have access to appropriate medical and mental health services daily. According to SDSD DSB P&P Section N.3 titled "Incarcerated Person Request Forms," incarcerated person request forms will be processed in an efficient and expeditious manner. All incarcerated person requests will be routed to the appropriate DSB personnel for timely review and response. Brink's jail medical file was reviewed; however, that information cannot be disclosed due to the Health Insurance Portability and Accountability Act (HIPPA) which protects the individual's sensitive health information. Medical treatment and care are made by jail medical staff and as such CLERB lacks jurisdiction to investigate further. 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 and the Review Board lacks jurisdiction for this allegation.

3. Misconduct/Procedure - The SDSD failed to provide IP Brink with "proper medical attention," resulting in additional injury.

   Board Finding: Summary Dismissal
   Rationale: Brink reported that he was suspected that he acquired COVID-19. Despite having a high temperature, jail medical staff did not test him for COVID-19 and disregarded condition. Later, Brink claimed he fainted and was transported to a hospital, where I was diagnosed with Guillain-Barré Syndrome (GBS), caused by COVID-19. In addition to the aggrieved's statement, the aggrieved's attorney, Attorney Pena provided the following statement, *"He woke up in the hospital with no feeling below his waist."* Brink's jail medical records were obtained and were reviewed. CLERB does not have any jurisdiction with Health Services staff members are non-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.

4. Misconduct/Procedure – The SDSD failed to house IP Brink in compliance with the Americans with Disability Act (ADA).

   Board Finding: Unfounded
   Rationale: Brink indicated that he was hospitalized from 08-18-23 to 08-26-23. Upon his discharge from the hospital, Brink said he was prescribed a wheelchair, as it was alleged that he could not walk without it, claiming that he sustained "two herniated disks." In his letter to CLERB, Brink explained that when he was discharged from the hospital, he had to use a wheelchair due to his alleged loss of motor function. Upon his return to jail, he claimed that he was placed in a jail cell that was not designated for someone in a wheelchair; that he was placed in a non ADA- compliant cell. Attorney Pena advised that "*At discharge, Mr. Brink was prescribed a wheelchair, as he could not walk without it. Despite Mr. Brink being discharged in a wheelchair and having no ability to walk under his own power, county staff failed to house Mr. Brink in ADA housing or a wheelchair- compliant cell."* Following [a second] *hospitalization, Mr. Brink was again housed in a non-ADA compliant cell."* An ADA-compliant jail cell must be physically accessible to people with disabilities. For an incarcerated person to be housed in an ADA- compliant jail cell the decision is a collaborative effort between the Jail Population Management Unit (JPMU) and the Medical Services Division. Medical/health staff authorizes and approves the need for an ADA- compliant jail cell, and JPMU assigns the appropriate housing unit and assigned cell to the incarcerated person. Also of note, the SDSD maintains an ADA Compliance Division. The ADA Compliance Division is a unit that handles all the Department's disability related accommodations, concerns, complaints, or questions regarding access to programs, facilities, or services of the SDSD. A SDSD Department Information Source, advised that the SDSD created the ADA Division/Unit in June 2023. The SDSD is currently in the process of increasing the number of wheelchair accessible beds/cells in its facilities. The SDSD ADA Division/Unit works cohesively with the Medical Services Division and the Jail Population Management Unit to oversee housing accommodations of all incarcerated persons with specific medical instructions. This joint effort is essential in finding appropriate housing for all incarcerated persons and in ensuring that all ADA housing accommodations are provided. Lastly, a scene investigation was performed at the SDCJ. Coupled with a review of all of Brink's assigned housing units and jail cells for both of his incarcerations, the investigation confirmed that every jail cell Brink

was assigned to was ADA-compliant and his allegation was false. The evidence showed that the alleged act or conduct did not occur.

5. Misconduct/Medical – Jail medical/health staff failed to provide IP Brink with after-hospital recommended care.

   Board Finding: Summary Dismissal
   Rationale: During his recovery, Brink alleged that he was denied physical therapy for his injuries. In his letter to CLERB, Brink explained that when he was discharged from the hospital he was to be treated by a specialist and undergo "intense physical therapy." The process of an incarcerated person being approved to undergo medical treatment or physical therapy typically starts with an evaluation and approval from the jail medical/health staff. The primary decision-makers in assessing and determining an incarcerated person's medical condition and determine the necessity for physical therapy is usually determined by the jail medical/health professionals within the SDSD Medical Services Division. 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 non-sworn jail medical staff and as such CLERB lacks jurisdiction to investigate further.

6. Misconduct/Procedure – Unidentified deputies failed to respond to IP Brink's medical emergency.

   Board Finding: Not Sustained
   Rationale: In his written letter to CLERB, Brink explained that on the night of 08-27-23, his cellmate attempted to summon deputies to their shared cell to report that Brink had experienced a medical emergency; however, the deputies did not acknowledge the emergency intercom. Attempts were made to contact Brink through his attorney to gather clarifying information; however, at the conclusion of this investigation, Brink was unable to be contacted. A review of jail documents did not reveal any noteworthy incidents involving Brink. Absent information provided by an independent witness to the incident or additional video or audio recordings of the interaction, there was insufficient evidence to prove or disprove the allegation.

23-099/NAVA (Inv. Wigfall)

1. Misconduct/Procedure – Deputy 1 placed Incarcerated Person Abraham Nava in Administrative Separation (Ad-Sep).

   Board Finding: Action Justified
   Rationale: Complainant Nava reported that another Incarcerated Person (IP) accused him of sexual assault, so he was placed in Ad-Sep for a month. SDSD P&P Section J.3 defines administrative separation as secure housing, where an IP may be housed per Jail Population Management Unit (JPMU) approval. SDSD documentation showed that while Nava was housed at San Diego Central Jail on 10-02-23, Deputy 1 spoke with Nava regarding his previous incidents and Nava agreed to be housed in Ad-Sep and completed a Housing Separation Order. In accordance with SDSD P&P Section R.1 Incarcerated Person Classification, the Jail Population Management Unit (JPMU) will conduct classification assessment and assign housing for all IPs. The evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

2. Misconduct/Procedure – An unidentified deputy placed Nava in "the hole."

   Board Finding: Not Sustained
   Rationale: Complainant Nava reported that an Incarcerated Person (IP) accused him of sexual assault, so he was placed in the "hole" for 3-4 days. Nava did not provide any dates for this event. SDSD documentation showed that on 08-17-23, Nava was placed in a safety cell. SDSD P&P defines a safety cell as a single occupancy temporary housing unit constructed with a padded surface and other security features. IPs may be placed in a safety cell temporarily if they are actively self-harming or actively assaultive. There was

insufficient evidence to determine if this incident is what Nava referred to in his complaint. CLERB was unable to prove or disprove the allegation.

3. Misconduct/Procedure – An unidentified deputy failed to adhere to policy for Nava's Disciplinary Hearing process.

   Board Finding: Unfounded
   Rationale: Complainant Nava stated that he was interviewed by detectives, but he did not receive any "write-up notices." SDSD P&P Section O.1 Disciplinary Action stated all IPs charged in any disciplinary action shall be afforded the due process provisions, which includes an appeal of their discipline. Policy also states that all incident reports that document a rule violation shall include a copy of the "incarcerated persons right's document. There was no evidence found that indicated Nava received a rule violation or that he was part of a disciplinary hearing. All incident reports and other SDSD documentation was reviewed and did not show any disciplinary action was taken on Nava. The evidence showed that the alleged act or conduct did not occur.

4. Misconduct/Procedure – An unidentified deputy lost/misplaced Navas property.

   Board Finding: Not Sustained
   Rationale: Complainant Nava reported after one month in Administrative Separation (Ad-Sep), an unidentified deputy instructed him to pack his personal property. Nava said the deputy then escorted him to a holding cell, while he awaited his new housing assignment, and he was instructed to leave his property outside the cell. Nava stated his property was moved, but he never received it. An Incident Report dated 09-12-23, documented 3 bags of missing property by Nava, however, there was no loss of property form found to have been submitted by Nava as required by SDSD DSB P&P Q.63 Lost Incarcerated Person Money or Property. SDSD documentation showed Nava was moved several times, throughout the facility and had inter-facility transfers, while incarcerated. There was no time reference for this allegation. There was insufficient evidence to either prove or disprove the allegation.

23-115/AUKSEL (Inv. Klew)

1. False Reporting – Deputies 1 and 2 reported that Joseph Auksel "retracted" his statement.

   Board Finding: Action Justified
   Rationale: Joseph Auksel, in his complaint to CLERB, alleged that he informed deputies he witnessed an alleged crime, but that the report of the incident indicated he retracted his statement. SDSD records showed on 08-19-23, SDSD deputies responded to a neighborly dispute in Jamul. Per SDSD documents related to this matter, the neighbors had been involved in an ongoing dispute regarding debris falling onto each other's property. One neighbor, who was on his property, allegedly had a handgun while the two parties were arguing. When deputies arrived, both parties were on their own properties and stayed separated. Deputy 1 interviewed Auksel, the complainant, as Auksel was a neighbor and allegedly observed the incident. A Crime/Incident Report written by Deputy 2 showed that Deputy 1 spoke with Auksel. Body Worn Camera (BWC) evidence of this interaction was available and subsequently reviewed as a part of this investigation. Deputies 1 and 2 provided confidential statements in a Sheriff Employee Response Form (SERF) that were considered in making a finding. Additionally, Deputy 2's report of this incident, BWC footage, as well as other involved deputies' BWC, were reviewed as a part of this investigation. Based on reports of this incident, Deputy 1's BWC footage and SERF response, no misconduct could be identified related to deputies actions in reporting this incident. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

2. Misconduct/Procedure – Deputies 1 and 2 did not make an arrest for a crime witnessed by Auksel.

   Board Finding: Action Justified
   Rationale: Auksel stated in his complaint to CLERB, "why did nothing happen to my neighbor that pulled out and brandished a firearm at another person unprovoked." Deputy 2's report indicated "due to multiple

circumstances, [Redacted] was not arrested for 417 (A)(2)(B)- Exhibit a firearm in a threatening manner." Deputy 2 also wrote "I elected to not place [Redacted] under arrest for the charge instead submitting the case for district attorney review for several reasons. When the incident occurred, [Redacted] was standing on his property and [Redacted] on his own. The two were arguing and based on both statements the argument grew increasingly hostile with both sides saying there were threats of a fight. Due to [Redacted]'s age and appearance, he would be at a significant risk for great bodily injury in a fight with [Redacted]. [Redacted] had also told Deputy [Redacted] that [Redacted] had begun walking towards him down the hill towards him causing him to believe a physical altercation was going to occur." Evidence showed a Crime Report was written and that charges were forwarded to the District Attorney's Office for review. Additionally, evidence showed that deputies seized the firearm that was alleged to have been used in the crime. No misconduct could be identified. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

3. Discrimination/Racial – Deputies 1 and 2 acted in a racially motivated manner.

   Board Finding: Not Sustained
   Rationale: Auksel stated, "I believe race was a part of these things because of my victim neighbor being black and having dreads." SDSD P&P 2.55 titled Non-Biased Based Policing, "Members of the San Diego County Sheriff's Department are prohibited from inappropriately or unlawfully considering race, ethnicity, religion, national origin, sexual orientation, gender, or lifestyle in deciding whether enforcement intervention will occur." "All personnel should treat the public equally without regard to race, gender, sexual orientation, gender identity or expression or disability, either physical or mental." No evidence could be identified which would indicate the involved deputies actions were racially motivated. To appropriately determine if a deputy is engaged in a pattern or practice of discriminatory behavior would require an investigation beyond that of this complaint and CLERBS' current jurisdiction. There was insufficient evidence to either prove or disprove the allegation.

23-120/JOHNSON (Inv. Wigfall)

1. Excessive Force – Deputies 2 and 4 used force towards an Incarcerated Person (IP) at the San Diego Central Jail.

   Board Finding: Action Justified
   Rationale: Complainant Johnson stated that while he was being booked at San Diego Central Jail on 09-07-23, he witnessed Deputies 2 and 4 use force towards an unknown IP. He reported the IP "turned on a deputy" and he got "slammed and punched multiple times" in his ribs/stomach and head/face area. Johnson described the incident as an "unnecessary/excessive use of force." SDSD documentation was reviewed and showed the IP was not cooperative with the booking process and refused to be taken into the intake/holding cell. The IP did not comply with deputy commands, displayed active resistance and subsequently assaulted a deputy. Deputies used a takedown technique and hand strikes toward the IP. Addendum F, Use of Force Guidelines states that hard hands control techniques, such as hand strikes are used to control more assaultive suspects. The guidelines also state that a fist strike to a subject's face when reasonable and necessary is not prohibited; however, it is preferable to use an open hand (palm heel) technique to reduce the likelihood of injury to the deputy's hand and subject's face. Jail surveillance video was observed and corroborated with deputy reports. SDSD P&P Section 6.48 Physical Force states that 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. The force used by deputies was reasonable given the totality of circumstances. The IP was medically evaluated and cleared to continue the booking process. CLERB did not obtain permission to review medical records. In addition, the San Diego Sheriff Public Records Center did not report this use of force incident as a Great Bodily Injury (GBI). The IP was contacted and offered the opportunity to provide a statement but did not respond. The evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

2. Misconduct/Procedure – Deputies 1, 3 and other unidentified deputies failed to obtain a witness statement from Sedric Johnson.

Board Finding: Not Sustained
Rationale: Complainant Johnson alleged he requested to provide Deputies 1 and 3 with a witness statement for the use of force incident. Johnson alleged deputies attempted to "block truth and suppress evidence" and they "failed to acknowledge him and failed to record his statement." See Allegation #1. Addendum F, Use of Force Guidelines states that supervisors and/or investigating deputies will make every attempt to identify and interview all necessary civilian witnesses to use of force incidents and professional staff employees who witness force resulting in serious injury shall be interviewed. The guidelines also reference when a use of force results in a complaint of injury or an injury that necessitates medical treatment, the supervisor will ensure that all witnesses were identified and interviewed. SDSD documentation showed that deputies reported the incident and provided a use of force supplemental, as required by policy. Johnson was not visible in the jail surveillance video during the use of force incident and given the limited information provided, it was unknown if Johnson's statement was imperative to the use of force review. Policy does not state that deputies must interview all witnesses in every use of force incident. There is insufficient evidence to determine to either prove or disprove the allegation.

23-123/URNEZIS (Inv. Wigfall)

1. Misconduct/Procedure – Deputy 4 handcuffed Incarcerated Person (IP) Zachary Urnezis.

   Board Finding: Action Justified
   Rationale: Complainant Urnezis stated he told deputies his handcuffs were on "too tight" but they did not do anything. According to the California Commission on Peace Officer Standards and Training, Arrest and Control, handcuffs are designed to temporarily restrain the subject. The handbook states that correct placement of handcuffs on the prisoner's wrists is essential for preventing injury or escape. Body Worn camera (BWC) was reviewed and showed deputies escorted Urnezis to a sobering cell while handcuffed. Urnezis stated his wrist hurt and the deputy told him to stop pulling. Urnezis asked the deputies to loosen the handcuffs, and Deputy 3 responded he would "take them off in a second." Evidence showed Urnezis moved his arms while he was handcuffed, which may have caused his discomfort. Once Urnezis was inside the cell and it was deemed safe, deputies removed the handcuffs. Photographs and jail medical records were also reviewed. The evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

2. Excessive Force – Deputy 1, 2 and 4 used force towards IP Urnezis.

   Board Finding: Action Justified
   Rationale: Complainant Urnezis stated the deputy used "excessive force" to handcuff Urnezis and claimed the handcuffs left "lacerations" on both of his wrists. He also stated deputies "threw" him and "slammed" him on the ground inside of a cell. See Rationale #1. Body Worn Camera (BWC) was reviewed and showed that deputies secured Urnezis in handcuffs and maintained arm guidance as they escorted him to a sobering cell. Deputy 1 patted Urnezis down, but Urnezis pulled away and hit his head against the cell door as he moved his body around and yelled. Deputy 4 used a wrist lock technique to prevent Urnezis' behavior from escalating. Deputies did not "throw" but guided Urnezis to the ground. Deputies also reported they placed Urnezis in a "shoulder pin" to restrict his movement and prevent him from hurting himself. SDSD P&P Section 2.49 Use of Force states employees shall not use more force in any situation than is reasonably necessary under the circumstances. Policy also states that 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 confrontation incident. The force deputies used to take control of Urnezis was reasonable. Evidence showed that the alleged act or conduct did occur but was lawful, justified and proper.

3. Misconduct/Procedure – Deputies 1 – 4 placed IP Urnezis into a cell with feces and vomit.

   Board Finding: Unfounded
   Rationale: Complainant Urnezis stated deputies "threw" him in a cell that had "feces smeared all over and vomit." He also stated the faucet had feces "all over it." Body Worn Camera was observed and refuted the allegation. The evidence showed that the alleged act or conduct did not occur.

4. Misconduct/Procedure – Detention deputies denied IP Urnezis drinking water.

   Board Finding: Not Sustained
   Rationale: Complainant Urnezis stated he "kept asking for water" but deputies did not bring him any. SDSD DSB P&P Section I.59 Access to Drinking Water states that toilets, wash basins, and drinking fountains must be provided in temporary holding cells, staging cells, sobering cells, single/double occupancy cells, dormitories, etc. Urnezis did not provide any further information (dates, time, etc.) about the alleged incident. There was insufficient evidence to either prove or disprove the allegation.

5. Misconduct/Discourtesy - Deputy 4 photographed IP Urnezis and repeatedly instructed him to smile.

   Board Finding: Not Sustained
   Rationale: Complainant Urnezis stated Deputy 4 took photos of him and told him "Smile, smile, you have to smile." SDSD P&P Section 2.22 Courtesy states employees shall be tactful in the performance of their duties, shall control their tempers, exercise patience and discretion even in the face of extreme provocation. Employees shall not use insolent language or gestures in the performance of his or her duties. Policy also states in Section 2.48 Treatment of Persons in Custody that Employees shall not mistreat, nor abuse physically or verbally, persons who are in their custody. Deputy 4 reported that he took photographs of Urnezis after the use of force incident, per policy. Deputy 4 was not equipped with Body Worn Camera, so the event was not captured on video. Urnezis failed to provide further information about the alleged incident and there was insufficient evidence to either prove or disprove the allegation.

6. Misconduct/Procedure – Unidentified deputies lost IP Urnezis' property.

   Board Finding: Not Sustained
   Rationale: Complainant Urnezis reported deputies did not transfer his property when he was moved from the 7th floor. Urnezis stated when he asked deputies for his property, he was told it was "not there." Urnezis reported he lost 2 bags with commissary items and books. SDSD DSB P&P Section Q.63 states when an IP is moved to another housing unit, the deputy shall ensure the person's module property is moved with the incarcerated person. A detentions deputy noted he provided Urnezis with a claim form for lost/damaged property and noted Urnezis received property on 10-10-23. There is no evidence that Urnezis submitted a lost/damaged property form. There was insufficient evidence to either prove or disprove the allegation.

23-144/DAVIS (Inv. Bohan)

1. Misconduct/Harassment – Deputy 1 called and emailed William Davis.

   Board Finding: Action Justified
   Rationale: Complainant William Davis stated, "I was contacted on my cell phone and at my email address by Deputy 1. I have forwarded a copy of the harassing emails sent to me by Deputy 1." On 05-04-23, a Domestic Violence (DV-130) Restraining Order was issued by the San Diego Superior Court for a period of five years. The Court Order identified William Davis as the Restrained Person and directed that Davis must stay at least 100 yards away from the protected party and must not contact the protected party, directly or indirectly, by any means, including by telephone, mail, email, or other electronic means. Violations of the Protective Order were reported to the San Diego Sheriff Department (SDSD). SDSD Detectives Manual Section D.2.2, Case Distribution and Processing, directs that all cases received by an area command will be assigned to a detective for review and investigation. Deputy 1 was assigned. Deputy 1 made contact with Davis on the phone and discussed the DV Protective Order with Davis. Davis acknowledged he knew there was a protective order. Davis denied that he emailed the protected party. He did, however, say he emailed the protected party's attorney but only once. Per SDSD Policy 6.55 Protective Orders, Deputy 1 informed Davis of the terms of the order and admonished Davis. Deputy 1 informed Davis that he had copies of the emails and text messages. Davis denied he attempted further contact with the protected party directly or indirectly. The evidence showed that the alleged act did occur and was lawful, justified and proper.

2. Misconduct/Procedure – Deputy 1 accused Davis of violating a restraining order.

Board Finding: Action Justified
Rationale: Complainant Davis stated, "I have been falsely accused of contacting/communicating with the protected party via email, from myself to their email address. I have not communicated with the protected party via email or telephone, other than 1 time, from 08-2022 thru 11-2023." During his investigation Deputy 1 was advised of a third violation in which Davis sent another email to the protected party, their attorney and a third party. After numerous failed attempts to contact Davis via phone, Deputy 1 emailed him. In the email exchange Deputy 1 informed Davis he was in violation of the served restraining order and he would be submitting the case to the District Attorney for review and consideration. Davis denied he emailed the protected party directly and/or indirectly. The evidence showed that the alleged act did occur and was lawful, justified and proper.

3. Misconduct/Truthfulness – Deputy 1 lied to Davis.

Board Finding: Unfounded
Rationale: Complainant Davis stated, "Deputy 1 is not telling the truth about this situation." Deputy 1 emailed Davis and informed him he was in violation of the served restraining order and he would be submitting the case to the District Attorney for review and consideration. Davis denied he emailed the protected party directly and/or indirectly and accused Deputy 1 of lying to him. The evidence showed the alleged act did not occur.

24-021/JOHNSON (Inv. Aldridge)

1. Misconduct/Procedure – The San Diego Sheriff's Department (SDSD) failed to maintain a safe shower area.

Board Finding: Summary Dismissal
Rationale: In Johnson's written letter to CLERB, he reported that on 10-08-23, he sustained an injury when he exited the jail module showers. Johnson explained, "*Suffered injury, coming out of the shower, tripping over the soapy stumps, causing me to fall forward. I have nerve damage due to a C6, C7 fusion. Nerve damage is in my right shoulder, arm, hand, so as I am falling, my right hand did open up fast enough, when I tripped falling forward, my body weight pressure is all on my upper body trying to catch myself with a bald fist smacking my right fist knuckles jamming my left middle finger, right hand knuckles area swelled up instantly. I filled out a medical grievance that day. I was able to put it in a medical box."* According to jail documents, at the time of incident, Johnson was housed at the George Bailey Detention Facility (GBDF). Though he was incarcerated at the time of his injury, Johnson's incident of sustaining a fall did not involve deputy misconduct. As such, CLERB lacks jurisdiction.

2. Misconduct/Procedure – Deputies 2 and 3 failed to recognize and respond to Johnson's medical emergency.

Board Finding: Not Sustained
Rationale: After sustaining the mechanical fall, Johnson advised that he informed deputies of the incident. Johnson reported, "*I notified correctional officer, 1, correctional officer, 3, correctional, officer, 2 I'm going to need medical attention*." According to jail records, Johnson notified another deputy of his injury and that deputy recognized and notated the injury, and immediately escorted Johnson to medical. Deputies 2 and 3 were served with a Sheriff's Employee Response Form (SERF) and questioned about their possible involvement. Deputies 2 and 3 provided information during CLERB's investigation that was considered in arriving at the recommended finding. Deputy statements are confidential and cannot be publicly disclosed. There was insufficient evidence to either prove or disprove the allegation.

3. Misconduct/Procedure – Deputy 1 failed to recognize and respond to IP Johnson's medical emergency.

Board Finding: Not Sustained
Rationale: See Rationale #2. Deputy 1 was also identified as one of the three deputies that Johnson claimed to have informed of his sustaining the mechanical fall, Johnson reported, "*I notified correctional officer, 1…. I'm going to need medical attention*." Deputy 1 did not respond to CLERB's request for information as required by CLERB's working agreement with SDSD. At the time of this investigation, Deputy 1 was

appointed to a temporary assignment that precluded his response. There was insufficient evidence to either prove or disprove the allegation.

4. Misconduct/Medical – Jail medical/health staff provided inadequate care to Johnson.

   Board Finding: Summary Dismissal
   Rationale: In his letter to CLERB, Johnson alleged that he received inadequate medical care during his incarceration. Johnson explained, "*After two weeks, I gotten a half arm splint, which didn't help my pain and suffering, nor the medical attention I needed. Like seeing a hand doctor. I was not able to x-ray till October 11. Spoke with a sergeant on video October 26. I believe I told him I wanted surgery. After he asked me what I wanted to do surgery or heal on its own. I said surgery specifically told him I wanted surgery before it heals. That was the last time I spoke or seen that sergeant. I've gotten another x-ray two weeks later on my left and right hand and it clearly shows my right hand was broken and was healing in a broken position. It's like they were knowingly, neglecting me not to have surgery when I it was needed. Like when it got broken three weeks plus prior then I get transferred to medical after filling out request forms and grievances letters, stating I have sleep apnea. Took medical staff 2½ months to get me to medical at the same time. I have a right broken hand and a broken left finger. Did not go see a specialist for hands until December 19. I was told it was to take too late for surgery and if they did surgery, they could damage my right hand even more than it's already damage. Now knowing my hand was defected. I just wish George Bailey staff responded sooner than later. I would not have a deformed right and left hand. I felt like this medical system, knowingly, neglected me for my condition*." Medical records were obtained from both the hospital and from the jail. That information cannot be disclosed due to the Health Insurance Portability and Accountability Act (HIPPA) which protects the individual's sensitive health information. Health Services staff members are not sworn staff. 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.

SUMMARY DISMISSAL (0)

End of Report

NOTICE

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