EXECUTIVE OFFICER
PAUL R. PARKER III

County of San Diego

CITIZENS' LAW ENFORCEMENT REVIEW BOARD

555 W BEECH STREET, SUITE 220, SAN DIEGO, CA 92101-2938
TELEPHONE: (619) 238-6776 FAX: (619) 238-6775
www.sdcounty.ca.gov/clerb

The Citizens' Law Enforcement Review Board made the following findings in the closed session portion of its March 9, 2021, meeting held via the BlueJeans Platform. 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	
Sustained	The evidence supports the allegation and the act or conduct was not justified.
Not Sustained	There was insufficient evidence to either prove or disprove the allegation.
Action Justified	The evidence shows the alleged act or conduct did occur but was lawful, justified and proper.
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 (6)

ALLEGATIONS, RECOMMENDED FINDINGS & RATIONALE

19-137

1. Misconduct/Harassment – Deputy 1 "harassed" the complainant.

Board Finding: Not Sustained
Rationale: The complainant stated, "I was asking to speak with mental health due to me being harassed by Deputy 1." The complainant failed to provide any specific details of when and how she was "harassed" or for how long the alleged "harassment" by Deputy 1 lasted. Jail records showed several documented incidents where the complainant targeted certain deputies and alleged that they were mistreating her. According to SDSD P&P Section 2.48 titled, Treatments of Persons in Custody, employees shall not mistreat, nor abuse physically or verbally, persons who are in their custody. Employees shall handle such persons in accordance with law and established Departmental procedures. Deputy 1 provided information during the course of CLERB's investigation that was considered in arriving at the recommended finding,

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however, it is privileged per the Peace Officer Bill of Rights (POBR) and cannot be publicly disclosed. Attempts were made to contact the complainant for additional information, however, they were unsuccessful. Absent additional information, as to the details of the alleged "harassment," there was insufficient evidence to either prove or disprove the allegation.

2. Misconduct/Procedure – An unidentified deputy denied the complainant's request for mental health.

   Board Finding: Not Sustained
   Rationale: The complainant stated, "On 11-24-2019 I was asking to speak with mental health due to me being harassed by Deputy 1 and I was denied." According to the complainant's Jail Information Management System (JIMS) Inmate History Summary Report, on 11-24-19, a documented entry showed that the complainant was seen and assessed by a Qualified Mental Health Provider (QMHP), however, it was not documented that the deputy summoned the QMHP when the complainant requested. SDSD P&P Section 2.23 titled, Request for Assistance, when any person requests assistance or advice, or makes complaints or reports, either by telephone or in person, all pertinent information will be obtained in an official and courteous manner, and will be properly and judiciously acted upon consistent with established Department procedures. There was insufficient evidence to either prove or disprove the allegation.

3. Excessive Force – Deputies 1 - 9 forcibly removed the complainant from her cell.

   Board Finding: Action Justified
   Rationale: The complainant stated, "The Lt [Lieutenant] came to my room and told me to move cells I refused to cuff up. The task force team came to my cell popped my cell came in with an tazer I grabed a chair but did not attacked anyone when the deputys got me down I was not resisting nore fighting." After being assessed by a Qualified Mental Health Professional (QMHP), it was determined the complainant needed to be moved to a Safety Cell due to her threats of harm to self and others, however, she refused, which resulted in the need for the forced extraction. SDSD DSB P&P Section J.1 titled, Safety Cells: Definition and Use, states in part, Inmates who have been assessed for Inmate Safety Program (ISP) housing may be temporarily placed in a safety cell when the inmate is actively self-harming or actively assaultive. The events were recorded on a handheld video recorder. Prior to the complainant being extracted from her cell, the Watch Commander (WC) was observed, in the handheld video recording, talking with the complainant. The WC made several attempts to get the complainant to cooperate. The complainant refused and argued. After warning the complainant that she would be forcibly removed, and the complainant's continued disregard of the situation, the WC thanked the complainant and walked away. Once assembled, deputies 1 - 9 entered the complainant's cell and removed her with force. SDSD DSB P&P Section I.83 titled, Extraction Procedures, states in part, the use of physical force to extract an inmate(s) from a cell or other area of the detention facility will only be used when the inmate(s) refuses to follow lawful orders, presents a danger to themselves or a danger to others. All extractions will be performed under the direct supervision of the watch commander or designee. Efforts will be made to communicate and reason with the inmate(s) involved to gain voluntary compliance with staff's orders. Inmates must be given at least two (2) verbal warnings to comply with orders prior to forceful extraction. At least one (1) of these warnings should be from the watch commander or designee on the scene. The WC was heard in the handheld video, stating to the complainant, "if you do not cuff up, we are going to come and remove you. I do not want you to get hurt, I want you to go willingly." The complainant stated, "No." The evidence showed that the forced removal of the complainant from her cell was lawful, justified and proper.

4. Excessive Force – Deputy 1 tasered the complainant.

   Board Finding: Not Sustained
   Rationale: The complainant stated, "I was tazered by Deputy 1 more times while restrained and cuffed and not resisting. On the gurney I was being tazed and hand tazered about 20 times with clothes on and 10 to 12 times after the whole incident tazered again with no clothes on." According to SDSD P&P Section 2.50 titled, Use of Lethal/less Lethal Weapons**,** employees shall not use or handle lethal or less lethal weapons (including chemical agents, saps, batons, taser guns, etc.,) in a careless or imprudent manner. Employees

shall use these weapons in accordance with law and established Departmental procedures. SDSD DSB P&P Section I.85 titled, Use of Defensive Devices – Conducted Energy Devices (CED), states in part, if it is necessary to apply the device, use the shortest, objectively reasonable duration of CED exposure to accomplish lawful objectives. Continuously reassess the inmate's behavior, reaction and resistance before initiating or continuing the exposure. Multiple applications or continuous cycling of a CED, resulting in an exposure longer than 15 seconds (whether continuous or cumulative), may increase the risk of serious injury or death and should be avoided if possible. Only one device should be deployed against a single suspect/inmate. According to Deputy 1's Use of Force (UOF) Report and the Taser Download Log, the CED was deployed 11 times, all drive stuns, for a total of 12 seconds. A drive stun is deployed by engaging the ARC switch causing energy to spark across all the electrodes or arc deflector metalized labels without deploying the cartridges. Drive-stun mode is not designed to cause incapacitation and primarily becomes a pain compliance option. In her UOF report, Deputy 1 provided that during the incident there were two instances when the complainant's "bucking and thrashing" caused her finger to slip off or disengage from the ARC button, deploying six ineffective accidental drive stuns. Deputy 1 provided information during the course of CLERB's investigation that was considered in arriving at the recommended finding, however, it is privileged per the Peace Officer Bill of Rights (POBR) and cannot be publicly disclosed. According to SDSD DSB P&P Section I.85 titled, Use of Defensive Devices, Deputy 1 was authorized to use a CED, as the policy states, in part, personnel shall be considered trained and qualified in CED use upon completion of a course of instruction coordinated by the Detention or Law Enforcement In-Service Training Unit. Additionally, the policy states, in part, when necessary and objectively reasonable to maintain or restore order, the watch commander or designee may authorize the use of defensive devices. SDSD P&P Addendum F titled, Use of Force Guidelines, states in part, CED shall only be used as a means of subduing or gaining control of a subject displaying assaultive behavior. Assaultive behavior is conduct that suggests potential for human injury, conveyed through body language, verbal threats, or physical actions. A Department Information Source indicated that someone, even when strapped down, can still be assaultive to deputies by grabbing hands, thrashing their body to strike a deputy, kick etc. Video footage of the incident included handheld video with audio and jail surveillance video with no audio. In the videos, portions of the complainant, at times, were blocked from view and on occasion complete view of the complainant was obstructed by deputies 1 - 9. When partial view of the complainant's body could be seen, it showed she was engaged in assaultive behavior. When the complainant was completely blocked from view it is unknown if she was engaged in assaultive behavior to justify being tased. Therefore, the evidence was insufficient to either prove or disprove the allegation that Deputy 1 excessively tased the complainant.

5. Misconduct/Procedure – Medical Staff did not document the complainant's injuries following a use of force.

   Board Finding: Summary Dismissal
   Rationale: The complainant stated, "medical seen my injuries and did not document them after the whole incident." Jail medical staff are non-sworn personnel and reside outside CLERB's jurisdiction per CLERB Rules & Regulations 4.1, Complaints: Authority. Pursuant to the Ordinance, CLERB shall only 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. As such, CLERB lacks jurisdiction and the allegation is summarily dismissed.

19-141

1. Excessive Force – Deputies 1 and 3 surrounded the complainant's vehicle at gunpoint.

   Board Finding: Action Justified
   Rationale: In the complainant's written statement, she reported, "*I was surrounded by Sheriff's deputies shining a light on me. They surrounded my car with guns drawn instructing me to keep my hands on the wheel. They asked for an ID… They instructed me to get out of the car…."* According to Deputy 1's SDSD Arrest/Juvenile Contact Report, based on the complainant's statements to the Sheriff's Communication Center dispatcher, Deputy 1 believed the complainant was armed and dangerous. Deputy 1 believed the complainant was dangerous because she was actively suicidal, threatening to kill herself by slitting her

wrists and throat. Being that the complainant was seated in a vehicle, the call of service was treated as a "high-risk stop;" the complainant was ordered out of the vehicle with weapons, both lethal and non-lethal, drawn. Deputy 1 knew from his training and experience that suicidal subjects could often turn violent towards law enforcement, especially if their intentions were to commit "suicide by cop." For these reasons, Deputy 1 drew his department-issued firearm and Deputy 3 drew his department issued less-lethal shotgun. Another deputy retrieved his department issued Pepperball Launcher, but did not aim it at the complainant and did not use it. Deputy 1 pointed his firearm at the complainant, he demanded she take the keys out of the ignition and put her hands up. Deputy 3 used his department issued, less-lethal shotgun, pointed it at the complainant, and ordered the complainant to exit her vehicle with her hands up. The complainant yelled at deputies and did not fully comply. Deputy 1 told the complainant she needed to follow his commands and that they were there to help her. Body Worn Camera (BWC) recordings were reviewed and corroborated the events that Deputy 1 articulated in his written report. According to SDSD P&P Section 8.1 titled, "Use of Firearms/Deadly Force," deputies shall use deadly force only as a last resort and only after the deputy reasonably believes that the force used is necessary: In defense of human life, including the deputy's own, in defense of any person in immediate danger of death, or the threat of serious physical injury. As a general rule, deputies shall not remove a firearm from the holster or display firearms unless there is sufficient justification. The evidence showed that the alleged act did occur and was lawful, justified and proper. The evidence showed that the alleged act did occur and was lawful, justified and proper.

2. Excessive Force – Deputies 1 and 3 used force to remove the complainant from her vehicle.

Board Finding: Action Justified
Rationale: In the complainant's written statement, she stated, "*The* [they] *grabbed my arms and dragged me to the ground. They dragged me across the asphalt and said "You need to comply" or words to that effect. When a deputy knelt on my back while others grabbed my arms and handcuffed me. I felt a pain in my back. They drag me handcuffed to the back of a deputy's car."* In a follow-up letter to CLERB, the complainant explained, "*I did not resist nor fight back when the deputies removed me from my vehicle."* According to Deputy 1's SDSD Arrest/Juvenile Contact Report, in response to her refusal to obey the deputies' commands, the deputies made the decision to detain the complainant for her safety and their safety. Deputies 1 and 3 approached the complainant in an attempt to detain her in handcuffs. The complainant actively resisted the deputies by using her own strength to keep her arms tucked close to her body, preventing them from handcuffing her. The complainant refused to lie flat on her stomach. In response to her refusal to comply, Deputy 1 used his right knee to put downward pressure on the complainant's left mid-back and left flank area and forced her to lay in a prone position. Deputy 1 used physical strength with both his hands to pull the complainant's left arm from behind her back. Had he not used force, the complainant could have injured him, his partner, or herself. In addition, the deputies didn't know if the complainant had a weapon (reportedly a box cutter) in her hands, or if she was injured. For these reasons, the deputies used force to handcuff the complainant and secured her so they could begin to evaluate and assess her, and ensure that the scene was safe. According to Deputy 3's SDSD Officer Report, during the incident, Deputy 3 grabbed the complainant's right hand with his hand and attempted to bring the complainant's right hand behind her back; however, she resisted his efforts to place her hand behind her back. The complainant tensed up and tried to keep her hands up above her head and parallel to the ground. Deputy 3 had to forcefully move the complainant's arm to place it behind her back in order to place her in handcuffs. According to Deputy 3, the force used to safely place the complainant in handcuffs was necessary to prevent the box cutter from being used against him or his partners, resulting in great bodily injury or death. The force Deputy 3 used was reasonable and necessary to effect a safe detainment. According to SDSD P&P Section 6.48 entitled "Physical Force," it shall be the policy of this Department whenever any Deputy Sheriff of this Department, while in the performance of his/her official law enforcement duties, deems it necessary to utilize any degree of physical force shall only be that which the Deputy Sheriff believes necessary and objectively reasonable to effect the arrest, prevent escape or overcome resistance. 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. Addendum Section F, Use of Force Guidelines, shall constitute the operating Procedures Section of P&P 6.48. The Use of Force Guidelines shall be considered a component of the

Department's Policy and Procedure Manual and as such, deputies will be held accountable for complying with its contents. In addition to the deputies' written reports, BWC from multiple deputies were viewed. The events and actions noted in the BWC records correlated with the events articulated in the deputies' reports. The evidence showed that the alleged act did occur and was lawful, justified and proper.

3. False Arrest – Deputies 1, 2, and 3 handcuffed and detained/arrested the complainant.

   Board Finding: Action Justified
   Rationale: In the complainant's written statement, she advised, "*They handcuffed me while I was still on the asphalt."* According to Deputy 1's SDSD Arrest/Juvenile Contact Report, deputies were called to respond for a suicidal female (the complainant) who threatened to slit her own throat and her wrist if deputies did not respond to her location within five minutes. Upon arriving to the complainant's location, and after a use of force, the complainant was handcuffed and detained pending an evaluation and assessment. According to the report, Deputy 1 detained the complainant, and Deputies 2 and 3 assisted with the detainment. Deputy 1 detained the complainant for an emergency psychiatric evaluation for being a danger unto herself, pursuant to California Welfare & Institute Code Section (WI §) 5150. The evidence showed that the alleged act did occur and was lawful, justified and proper.

4. Excessive Force – Deputy 1 injured the complainant.

   Board Finding: Action Justified
   Rationale: In the complainant's written statement, she reported, "*I complain that my ribs might be broken. The deputy said you wouldn't be able to talk if that was the case. I was taken to the hospital where it was determined that my ribs were broken."* In a follow-up letter to CLERB, the complainant explained, "*I was taken to Sharp Grossmont Hospital…"* According to Deputy 1's SDSD Arrest/Juvenile Contact Report, during the use of force, Deputy 1 attempted to detain and handcuff the complainant; however, the complainant actively resisted the deputies by using her own strength to keep her arms tucked close to her body, preventing them from handcuffing her. The complainant refused to lie flat on her stomach so the deputies could secure her. In response to her refusal to comply, Deputy 1 used his right knee to put downward pressure on the complainant's left mid-back and left flank area (latissimus dorsi muscle) and forced her to lay in a prone position. After the use of force, the complainant was transported to Sharp Grossmont Hospital where she was admitted for a psychiatric evaluation. Deputy 1 took photos of the complainant and her injuries for documentation. Deputy 1 also notated in his report that the complainant claimed that her ribs were broken, and complained of pain to her left side. The complainant supplied CLERB with one page of medical a record from Sharp Grossmont Hospital. According to the document, dated 11-06-19, the complainant was seen by an Emergency Department physician and had a x-rays taken of her left ribs. The x-rays revealed a fracture of the complainant's left, 6th rib. The complainant was discharged from the hospital on 11-06-19. The evidence showed that the alleged act did occur and was lawful, justified and proper.

5. Illegal Search & Seizure – Deputy 1 transported the complainant away from the incident location.

   Board Finding: Action Justified
   Rationale: In the complainant's written statement, she stated, "*I was driven by a deputy to a secluded spot…"* In a follow-up letter to CLERB, the complainant explained, "*I was taken to a nearby parking lot, near a Carl's Jr. I do not know why I was driven away from the scene. I am not sure how far away it was that I was taken."* According to Deputy 1's SDSD Arrest/Juvenile Contact Report, after the complainant was handcuffed, she was placed in the rear seat of Deputy 1's patrol vehicle and was transported off the freeway. Deputy 1 transported the complainant off the freeway for her safety as well as his safety. In his report, Deputy 1 notated that during the incident, he took cover behind his patrol vehicle's passenger door to prevent being hit by passing vehicles which were traveling past them at high rates of speed. Deputy 1 transported the complainant to a nearby restaurant. Upon reaching the restaurant parking lot, Deputy 1 summoned paramedics to the scene to evaluate the complainant. The complainant was driven from the incident location to the restaurant parking lot. According to Google Maps, which was accessed on 01-26-21, the estimated distance from the incident location, to the restaurant where the complainant was driven

to, was approximately 0.2 to 0.4 miles, with an estimated drive time of one to two minutes, depending on traffic. Upon reviewing BWC recordings, it was noted that it took Deputy 1 one minute and three seconds to drive from the incident location, to the parking lot of the nearby restaurant. The restaurant parking lot was not a secluded spot, but was a well-lit, occupied parking lot almost immediately off the highway. Additionally, in Deputy 1's BWC recording, he clearly articulated to the complainant, numerous times, that he was transporting her off the freeway for her safety, as well as his safety. The evidence showed that the alleged act did occur and was lawful, justified and proper.

6. Illegal Search & Seizure – Deputy 2 impounded the complainant's vehicle.

   Board Finding: Action Justified
   Rationale: In the complainant's written statement, she advised*, "My car was impounded and I lost it because I could not pay the impound fine."* According to Deputy 1's SDSD Arrest/Juvenile Contact Report, Deputy 1 noted that the complainant's vehicle was towed from the scene. According to a SDSD Notice of Stored Vehicle report, as well as a SDSD Impound Report, both dated 11-05-19, the complainant's vehicle was towed from the incident location in Spring Valley on 11-05-19, at 10:10pm. The vehicle was towed in accordance with California Vehicle Code Section (CVC§) 22651(h)(1), disposition of vehicle when a driver is arrested. The vehicle was stored at the tow yard in accordance with CVC§ 22651(c) The form was completed by Deputy 2. According to California Vehicle Code Section 22651(g), a peace officer may remove a vehicle located within the territorial limits in which the officer or employee may act, under the following circumstances: (g) If the person in charge of a vehicle upon a highway or public land is, by reason of physical injuries or illness, incapacitated to an extent so as to be unable to provide for its custody or removal, or (h)(1) If an officer arrests a person driving or in control of a vehicle for an alleged offense and the officer is, by this code or other law, required or permitted to take, and does take, the person into custody. According to SDSD P&P Section 2.51 entitled, "Arrest, Search and Seizure," employees shall not make any arrest, search or seizure, nor conduct any investigation or official Department business, in a manner which they know or ought to know is not in accordance with law and established Department policies and procedures. According to SDSD P&P Section 6.36 entitled, "Impounded/Stored Vehicle Reporting," whenever a vehicle is removed and stored from public or private property by members of this Department, a notice of storage stating the removal, the authority and the location of the storage yard shall be mailed to the registered and legal owners within two business days, with a copy sent to the tow yard. According to SDSD P&P Section 6.37 entitled, "Towing Policy," when vehicles are towed and/or stored, the removal shall be in compliance with Vehicle Code 22651 or other lawful authority. Under no circumstances shall the act of towing and/or storing of a vehicle be used as a means of punishment against any citizen. All stored or impounded vehicles shall be inventoried prior to removal by a tow company. The removal of any vehicle during or after an arrest shall only be authorized in the following situations: A vehicle may be towed when a deputy arrests any person driving or in control of a vehicle for an alleged offense and the deputy is required or permitted to take and does take the person arrested before a magistrate without unnecessary delay. The evidence showed that the alleged act did occur and was lawful, justified and proper.

20-045

1. Misconduct/Procedure – SDSD did not provide the aggrieved with "due process".

   Board Finding: Summary Dismissal
   Rationale: The complainant stated, "My brother, is contained at George Bailey Detention Facility (GBDF) and has yet to have a preliminary hearing in over one year." According to his booking records, on 04-02-19, the People of the State of California issued a warrant to produce the inmate from state prison to answer to charges for further proceedings of his criminal complaint(s). Subsequent court proceedings occurred on 05-03-19, 05-07-19, 05-31-19, 06-18-19, 08-07-19, 11-19-19, and 12-09-19 until a Psychiatric Examination was ordered by the Court on 01-09-20. Based upon the aggrieved's non-cooperation, the trial was suspended until another mental health evaluation could be conducted. A review of the inmate's Jail Information Management System (JIMS) records confirmed that SDSD produced the inmate for his legal

hearings. Court proceedings are determined by the court system over which CLERB does not maintain any jurisdiction.

2. Misconduct/Procedure – SDSD failed to provide basic necessities to the aggrieved/inmates.

   Board Finding: Not Sustained
   Rationale: The complainant stated, "The treatment and conditions are horrific and fall well beneath what would be considered acceptable treatment for inmates and definitely not how any human being should be treated. Prison and jail conditions violate the Eighth Amendment if they deprive a person of "the minimal civilized measures of life's necessities." These "basic human needs" are "adequate food, clothing, shelter, sanitation, medical care and personal safety." A condition may violate the Eighth Amendment even if it has not yet caused any significant injury to a person, so long as there is a "sufficiently imminent danger." Also, the length of the deprivation can be a factor in whether or not the Eighth Amendment is violated: "A filthy, overcrowded cell and a diet of 'grue' might be tolerable for a few days and intolerably cruel for weeks or months." The jail conditions described by the complainant did not specify any type of deputy misconduct. The Regulation and Policy Management Branch (RPMB) of the California Department of Corrections and Rehabilitation is responsible for managing the development, revision, and adoption of regulations related to Adult Institutions through the Title 15 Minimum Standards for Local Detention Facilities. i.e. Articles 11-15 regarding Medical/Mental Health Services; Food, Inmate Clothing and Personal Hygiene; Bedding and Linen; and Facility Safety and Security; numerous related detention policies also apply. Section 4 of CLERB Rules & Regulations outlines CLERB's jurisdiction over sworn personnel only, and defines misconduct as any alleged improper or illegal acts, omissions, or decisions directly affecting the person or property of a specific person arising out of the performance of the peace officer's or custodial officer's official duties. The allegation did not specify any deputy misconduct and they were referred to the American Civil Liberties Union (ACLU). There was insufficient evidence to prove or disprove sworn personnel's involvement in this allegation.

3. Misconduct/Medical – SDSD failed to implement COVID-19 protocol at the detention facilities.

   Board Finding: Summary Dismissal
   Rationale: The complainant stated, "GBDF's response to the CV-19 is nonresponsive, there is no plan, the guards are worried about their own health and the situation at the jail. Several guards indicated that they are worried because they are expecting more inmates to be transferred there and there is no plan on how to handle the situation. According to the ACLU, San Diego facilities are required to have a cornonavirus-19 plan, which Bailey does not have it. It is critical this plan be enacted immediately, 'Incarcerated people are highly vulnerable to contagious illnesses because they live in close quarters and because medical care in these facilities has been documented to be severely inadequate.'" On 02-11-20, the World Health Organization (WHO) identified COVID-19 as the disease responsible for causing the 2019 novel coronavirus outbreak. On 03-12-20, the San Diego County Public Health Officer issued orders followed by Governor Gavin Newsom issuing directives on 03-13-20 to protect the health and well-being of all Californians and to establish consistency across the state in order to slow the spread of COVID-19; there have been numerous amendments to the original orders. On 03-20-20, SDSD deployed their Continuity of Operations Plan (COOP) in response to the threat of the novel coronavirus (COVID-19) pandemic. Precautions taken included daily temperature checks; daily and deep-cleaning protocol; inmate isolation; and COVID-19 Identification and Tracking. SDSD also instituted mandatory cloth face coverings for staff, visitors, and inmates in accordance with the Centers for Disease Control (CDC) guidelines on/around 04-04-20. According to a Training Bulletin issued 04-13-20, cleaning/sanitizing carts were to be utilized as often as possible between dayroom times, after each meal, and during lockdown hours for "high touch and common areas," with higher standards required for all known infected areas. A 11-16-20 news release, reported that symptomatic inmates at GBDF were isolated, tested and quarantined. A subsequent News Release on 11-20-20, provided an update on the GBDF outbreak. Section 4 of CLERB Rules & Regulations outlines CLERB's jurisdiction over sworn personnel only and defines misconduct as any alleged improper or illegal acts, omissions, or decisions directly affecting the person or property of a specific person arising out of the performance of the peace officer's or custodial officer's official duties.

The allegation did not specify any deputy misconduct. There was insufficient evidence to prove or disprove sworn personnel's involvement in this allegation.

4. Misconduct/Procedure – SDSD failed to provide inmates with masks and/or sanitizing disinfectants during the COVID-19 crisis.

   Board Finding: Not Sustained
   Rationale: The complainant stated, "They were told there were not enough masks for all the inmates, and the lucky ones who received them are only the handmade cloth ones that do not stop the virus from infecting others, plus they are not sanitized daily (or ever). These are all Eighth Amendment violations." A review of the aggrieved's booking records revealed a group disciplinary write-up on 03-28-20 due to inmates refusing to lockdown. The basis for the delay in operations included inmates asking for deputies to wear facemasks, and inmates requesting that facemasks be distributed throughout the module. According to available records, SDSD's Medical Services Division (MSD) implemented safety protocols to include masks for inmates and staff occurred shortly thereafter, in accordance with CDC guidelines. A 04-21-20 Press Release also reported that students in the the Sheriff's job training sewing program had made 10,000 masks since March for inmates at all seven of the Sheriff's detention facilities. Sanitizing protocol was addressed in Rationale #3. Section 4 of CLERB Rules & Regulations outlines CLERB's jurisdiction over sworn personnel only, and defines misconduct as any alleged improper or illegal acts, omissions, or decisions directly affecting the person or property of a specific person arising out of the performance of the peace officer's or custodial officer's official duties. This allegation did not specify any deputy misconduct. There was insufficient evidence to prove or disprove sworn personnel's involvement in this allegation.

5. Misconduct/Procedure – SDSD moved the aggrieved.

   Board Finding: Action Justified
   Rationale: The complainant stated, "My brother was in a cell with one other cellmate until last week when GBDF corralled them into dormitory type living with 50-60 other inmates. Inmates were told they were being moved due to an outbreak of CV-19, including medical personnel and guards testing positive. (Now there are inmates who have tested positive). As of this morning (4/12/2020) the inmates were told there are no CV-19 positive tests reported in that facility, this is after they were told the new living quarters and restrictions were due to the outbreak." Housing changes/movements are based upon the census of the detention facilities and specific needs of each individual inmate. Per DSB Policies pertaining to Classification, (R.1 and R.3) an inmate's initial classification is determined by their original booking charges, criminal history, medical and psychiatric issues or any other special conditions; inmates can also be reclassified at any time. Separation due to infectious control purposes is determined by the Medical Services Division (MSD), over which CLERB has no authority. The aggrieved's classification records on 04-09-20, confirmed he was housed in general population as a sentenced inmate, who was a prison return, with no strikes. He was moved a total of eight times from 05-08-19 through 04-11-20; six moves were within the same housing unit and the last two in April of 2020 were to dorm-style housing. The aggrieved's movements were within his classification and in accordance with policy. The evidence showed that the alleged act or conduct did occur and was lawful, justified and proper.

6. Misconduct/Procedure – SDSD restricted inmate services.

   Board Finding: Action Justified
   Rationale: The complainant stated, "The treatment of these inmates is alarming; they are in lockdown 23.5 hours per day; not given any outside time or exercise time; have not been allowed to cut nails, shave faces, or get haircuts in over a month and there are no plans to allow this in the foreseeable future. They are only allowed to change clothes once per week (including undergarments). They are forced to eat on the floor after removing tables/benches from the module." Title 15 Guidelines in accordance with detention policies specifies the procedures pertaining to Inmate Rights and Services/Programs, which were reduced/restricted during the COVID-19 pandemic by order of the Health Officer and per DSB Policy M.37, Standard Precautions and Infectious Agents/Communicable Disease Control. Section 4 of CLERB Rules

& Regulations outlines CLERB's jurisdiction over sworn personnel only, and defines misconduct as any alleged improper or illegal acts, omissions, or decisions directly affecting the person or property of a specific person arising out of the performance of the peace officer's or custodial officer's official duties. This allegation did not specify any deputy misconduct. The evidence showed that the conduct that occurred was lawful, justified and proper.

7. Misconduct/Medical – SDSD failed to provide medical care to the aggrieved.

   Board Finding: Summary Dismissal
   Rationale: The complainant stated, "There is no medical care being given. My brother has filed over 20 grievances after being denied medical care, including reporting that he had a heart attack 10 days ago, has a heart defect, susceptible to pneumonia, and is diabetic, yet he has still not seen a doctor." Detentions Policies M.1 Access to Care, means that, in a timely manner, a patient is seen by a qualified health care professional, is rendered a clinical judgment, and receives care that is ordered, and M.15 Sick Call, specifies that this occurs on a daily basis. Section 4 of CLERB Rules & Regulations outlines CLERB's jurisdiction over sworn personnel only, and defines misconduct as any alleged improper or illegal acts, omissions, or decisions directly affecting the person or property of a specific person arising out of the performance of the peace officer's or custodial officer's official duties. This allegation did not specify any deputy misconduct; the Review Board lacks jurisdiction.

8. Misconduct/Discourtesy – An unidentified deputy told the aggrieved to "shut up".

   Board Finding: Not Sustained
   Rationale: The complainant stated, "He (the aggrieved) was told by the corporal they do not care about his medical condition and to shut up." Sheriff's Policy, 2.22 Courtesy, mandates that employees be courteous, tactful in the performance of their duties, control their tempers, exercise patience and discretion even in the face of extreme provocation and are prohibited from using coarse, profane or violent language. The complainant/aggrieved did not provide additional information pertaining to the person, date, time of this incident. There was insufficient evidence to either prove or disprove the allegation.

9. Misconduct/Procedure – An unidentified deputy limited sick call request form(s).

   Board Finding: Not Sustained
   Rationale: The complainant stated, "The number of requests to seek medical treatment and the number of grievances filed by my brother should not happen and is putting him at risk of developing further medical complications and possible death. According to the CDCR policy, medical services that are necessary to protect life, prevent significant illness or disability, or alleviate severe pain should be rendered. The Health Care Grievance procedure includes using specific forms, which my brother has used and has been told by the corporal that he can only have one regardless of the number of medical grievances he needs to file." Detentions Policies M.1 Access to Care, means that, in a timely manner, a patient is seen by a qualified health care professional, is rendered a clinical judgment, and receives care that is ordered, and M.15 Sick Call, specifies that this occurs on a daily basis. Furthermore, Sick Call Request (J-212) forms are available to all inmates on a daily basis in their housing units and are deposited by the inmate into the secure medical mailbox provided in the housing unit. Facility health staff are then responsible for collecting the sick call requests from the housing units each night after hard count. The complainant/aggrieved did not provide additional information pertaining to the person, date, time of this incident. There was insufficient evidence to either prove or disprove the allegation.

20-046

1. Misconduct/Procedure – SDSD refused to provide razors to inmates.

   Board Finding: Action Justified

Rationale: The complainant stated, "I came to find out that same day when we finally were let out to day room that none of the guys on the bottom got any razors either, I was told this by a gentle man down on cell 32 that wat I witnessed was the coprol & a trainy passing out welfare packs I explained to him that there is a lot of crooked actions taking place at this facility, so although they were supposed to pass out razors to everyone they flat out did not even after speaking to a Sgt, passing by I asked are we getten razors he answered your supposed to & so what happeded we got screwed till Sunday night the 19th." Detentions Policy L.7, Razors states that all inmates will have access to a razor on a daily basis except those inmates who have a razor restriction for health and/or safety reasons. The complainant grieved this issue on 03-29-20 and was advised that razors were only issued to inmates with court appearances, as it was a health and safety concern. SDSD implemented measures to prevent an outbreak during the COVID-19 pandemic by order of the Chief Health Officer and per Detentions Policy M.37, Standard Precautions and Infectious Agents/Communicable Disease Control. The evidence showed that the actions that occurred were lawful, justified and proper.

2. Misconduct/Procedure – Unidentified sergeants did not respond to the complainant's grievances.

   Board Finding: Unfounded
   Rationale: The complainant stated, "There's corruption at the Vista Jail because sergeants do not respond to my grievances so I stopped filing them because nothing's done." The complainant forwarded two grievances as evidence. The first, dated 04-24-20, pertained to a request for a nail clipper. A nurse responded the following day that clippers were unavailable due to the COVID-19 pandemic. Another grievance dated 04-26-20 was in reference to cleaning supplies to which a sergeant responded the following day and resolved the issue. SDSD records confirmed that the complainant submitted a number of "Inmate Grievances" that were in fact "Inmate Requests," and were documented in accordance with Detentions Policy N.1. The policy allows informal resolution of an issue to be handled at the lowest level, and without the intervention of a supervisor. The evidence showed that the allegation, as stated by the complainant, did not occur.

3. Misconduct/Procedure – SDSD denied programs to inmates.

   Board Finding: Action Justified
   Rationale: The complainant stated, "…so so far we get no hair cuts, no nail clippers, no program we spend 23 hours of the day locked down in spite that no no one here is sick or infected they keep us in our cells all the time it is outrageous & completely fucked up unfair treatment they treat us worse than animal they truly don't even care that not all of us get a chance to get in the shower pure inconsideration I am truly appalled at the unethical inadequate performance of all this system. we are all sick and tired of this mistreatment." The complainant also grieved these issues that were responded to by command staff and explained that every effort had been made to give the complainant access to the dayroom to shower, but his boisterous behavior became a safety concern and he was provided hygiene products as an alternative on one occasion. Surveillance video corroborated the reported information. Title 15 Guidelines in accordance with detention policies specifies the procedures pertaining to Inmate Rights and Services/Programs, which were reduced/restricted during the COVID-19 pandemic by order of the Health Officer and per DSB Policy M.37, Standard Precautions and Infectious Agents/Communicable Disease Control. The evidence showed that the conduct that occurred was lawful, justified and proper.

20-096

1. Death Investigation/Natural (Possible Drug-Related) – Mark Armendo experienced a medical emergency on 06-29-20 while incarcerated at the Vista Detention Facility (VDF); he was hospitalized and his condition deteriorated until his death on 08-21-20.

   Board Finding: Action Justified
   Rationale: A review of the available evidence associated with this case indicated that on 06-29-20, Mark Armendo suffered a medical emergency that was initially believed to be an overdose. Upon being advised

of a “mandown,” sworn and medical personnel responded, determined Armendo had no pulse and was not breathing, and initiated life-saving measures in compliance with M.6, Life Threatening Emergencies. Armendo was administered multiple doses of naloxone as a precaution, as it has no adverse effects. After approximately 13 minutes of resuscitative efforts, Armendo began breathing on his own. He was transported to Tri-City Medical Center (TCMC). A subsequent urine toxicology screen at the hospital was negative for any drugs of abuse, however, the screen did not specifically test for fentanyl. While hospitalized, Armendo was treated for seizures, pneumonia, and a possible heart attack. After being transferred to UCSD Medical Center for a higher level of care on 07-04-20, Armendo’s sentence was recalled and he was released by court order from Sheriff’s custody on 07-07-20. Armendo developed MRSA (methicillin resistant staphylococcus aureus) and the seizures continued while his health declined. Armendo never recovered and his death was pronounced while in the hospital on 08-21-20. The death certificate listed the cause of death as pulmonary embolism due to MRSA due to seizures. Armendo had a positive COVID diagnosis according to hospital records and the court order for his release, but the investigation was unable to determine when/where he contracted the virus. COVID-19 Identification/Tracking was instituted at the detention facilities as early as 03-20-20; all inmates presenting symptoms of COVID-19 or other respiratory illnesses were tested and those with positive results were quarantined to contain the spread of any disease. While CLERB did not have access to Armendo’s entire medical file, the available evidence suggested that Armendo did not test Covid positive until hospitalized. A search of Armendo’s cell resulted in contraband associated with illicit substances. During CLERB’s investigation, CLERB staff discovered that sworn members of the Detentions Investigations Unit (DIU) had obtained a search warrant for and collected Armendo’s blood taken at TCMC upon his admission. The Sheriff’s Department’s Crime Lab results confirmed the presence of fentanyl (0.8 ng/mL) and norfentanyl (0.3 ng/mL) in his blood. As there was no indication that the Medical Examiner’s Office was aware of the results of the hospital admission blood testing, CLERB forwarded this information and requested reconsideration and possible amendment of the cause and manner of death. The evidence showed that the actions taken by sworn personnel related to Armendo’s medical emergency were lawful, justified and proper.

2. Misconduct/Medical – “County jail officials” failed to take reasonable measures and/or were “deliberately indifferent” to risk(s) inmates faced while incarcerated during a pandemic.

   Board Finding: Summary Dismissal
   Rationale: The complainant stated, “County jail officials failed to take reasonable measure to abate the high risk that those in County custody would contract COVID-19 in County jails, and jail officials were deliberately indifferent to the excessive risks this posed to inmates' health.” According to media articles, the Sheriff’s department has been criticized over its COVID-19 practices. SDSD has publicly reported that since the start of COVID-19, they implemented pandemic-related safeguards to protect the inmate population. The Sheriff’s Department issued a Press Release on 04-24-20 providing an update on COVID-19 and County Jails stating there was a mandatory seven-day quarantine period for anyone booked into custody, and the Sheriff's Medical Services Division implemented protocols and a discharge process for individuals housed in isolation modules and/or have tested positive for COVID-19. Per their Training Bulletins and Press Releases, other actions taken include isolation/quarantine, testing, cleaning/sanitizing, mask coverage, as well as guidance by the Public Health Officer for congregate living facilities to “keep the community and inmate population safe from exposure and infection to the best of their ability.” Section 4 of CLERB Rules & Regulations outlines CLERB’s jurisdiction over sworn personnel only and defines misconduct as any alleged improper or illegal acts, omissions, or decisions directly affecting the person or property of a specific person arising out of the performance of the peace officer’s or custodial officer’s official duties. This complaint, filed by Armendo’s family, did not specify any deputy misconduct. SDSD implemented measures to prevent an outbreak during the COVID-19 pandemic by order of the Chief Health Officer and per Detentions Policy M.37, Standard Precautions and Infectious Agents/Communicable Disease Control. Care/Treatment of the COVID-19 virus is a medical issue and medical staff and their decision(s) reside outside CLERB’s purview. The Review Board lacks jurisdiction.

3. Misconduct/Medical – Unidentified Sheriff’s personnel were “deliberately indifferent, reckless and grossly negligent” in their care of Mark Armendo.

Board Finding: Summary Dismissal
Rationale: The complainant stated, “Around the end of June 2020 and the beginning of July 2020, Mark Armendo was a prisoner at the Vista Jail in the care and custody of San Diego County Sheriff's Department. Around the same time frame, Mr. Armendo became seriously ill experiencing, among other things, symptoms related to a COVID-19 infection. County jail officials failed to take reasonable measure to abate the high risk that those in County custody would contract COVID-19 in County jails, and jail officials were deliberately indifferent to the excessive risks this posed to inmates' health. Jail officials were, moreover, deliberately indifferent to the serious medical risks and needs Mr. Armendo faced after contracting COVID-19 while in County custody. At a minimum, County jail officials’ response to COVID-19 in County jails, as well as their response to Mr. Armendo’s serious medical risks and needs, was reckless and grossly negligent. As an actual and foreseeable result of this deliberate indifference, recklessness, and/or gross negligence, Mr. Armando died.” Detentions Policy M.1, Access to Care, establishes guidelines for reasonably prompt access to medical services for any inmate complaining of illness or injury, and states that any inmate 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 their Training Bulletins, on 03-20-20, SDSD deployed their Continuity of Operations Plan (COOP) in response to the threat of the novel coronavirus (COVID-19) pandemic. Precautions taken included daily temperature checks, daily and deep-cleaning protocol, inmate isolation, and COVID-19 Identification and Tracking. On or around 04-04-20, when the Centers for Disease Control (CDC) provided recommendations for the use of cloth face coverings to slow the spread of COVID-19, SDSD instituted mandatory cloth face coverings for staff, visitors and inmates. Hospital records corroborated that Armendo tested positive for COVID-19, however, the investigation was unable to determine how and when he contracted the virus. While CLERB did not have access to Armendo’s entire medical file, the available evidence suggested that Armendo did not test Covid positive until hospitalized. Blood test results also confirmed that Armendo had fentanyl and norfentanyl in his system upon admission to the hospital. Section 4 of CLERB Rules & Regulations outlines CLERB’s jurisdiction over sworn personnel only, and defines misconduct as any alleged improper or illegal acts, omissions, or decisions directly affecting the person or property of a specific person arising out of the performance of the peace officer’s or custodial officer’s official duties. SDSD implemented measures to prevent an outbreak during the COVID-19 pandemic by order of the Chief Health Officer and per Detentions Policy M.37, Standard Precautions and Infectious Agents/Communicable Disease Control. The Review Board lacks jurisdiction. See Rationale #1 for additional information.

21-005

1. False Reporting - Deputy 1 wrote a false police report.

   Board Finding: Summary Dismissal
   Rationale: The complainant reported that on 07-09-09, he tossed a milk carton containing “water” at a pill cart. Deputy 1 then wrote a false police report and exaggerated the evidence to the District Attorney’s Office, and the complainant was charged with PEN§ 243.9(a) Gassing, intentionally placing or throwing, or causing to be placed or thrown, upon the person of another, any human excrement or other bodily fluids or bodily substances or any mixture containing human excrement or other bodily fluids or bodily substances that results in actual contact with the person's skin or membranes. CLERB Rules and Regulations requires that complaints be filed within one year of the incident date giving rise to the complaint. The complainant failed to sufficiently demonstrate that his incarceration prevented him from filing a timely complaint. Furthermore, Deputy 1 departed employment with SDSD on 10-08-09. Because the subject officer is no longer employed, witness personnel and evidence are no longer available, and this complaint is untimely, CLERB lacks jurisdiction per CLERB Rules & Regulations 4.1.2.

2. Misconduct/Procedure – Unidentified personnel did not make evidence available to the complainant.

   Board Finding: Summary Dismissal

Rationale: The complainant reported that he did not receive the photographs, police report, and/or DVD(s) of the 07-09-09 incident. There was no identification of personnel in this allegation. See Rationale #1.

3. Excessive Force – Unidentified deputies “slammed” the complainant to the floor and fractured his nose.

   Board Finding: Summary Dismissal
   Rationale: The complainant reported two deputies slammed him to the floor and partially fractured his nose during a cell extraction. There was no identification of personnel in this allegation. See Rationale #1.

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.