Annual Report 2025

County of San Diego
Citizens' Law Enforcement Review Board (CLERB)

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INTRODUCTION

MISSION

CLERB's mission is to increase public confidence in and accountability of any peace officer, custodial officer, employee or contractor, including any contract health care provider, working under the direction of the Sheriff's Office or Probation Department by conducting independent, thorough, timely, and impartial reviews of Complaints of misconduct and deaths.

PURPOSE

CLERB shall receive, review, investigate and report on Complaints in accordance with the Rules and Regulations. The rules are to provide for the independent, thorough, timely, and impartial investigation of Complaints, deaths of individuals arising out of or in connection with actions of peace officers, employees, custodial officers, and employee and contracted Health Care Providers employed by the Sheriff's Office or the Probation Department, and other specified incidents in a manner that a) protects both the public and the Departments, Sheriff and Probation, that are involved in such Complaints, and b) enhances the relationship and mutual respect between the Departments and the public they serve.

CLERB shall publicize the review process to the extent permitted by law in a manner that encourages and gives the public confidence that they can come forward when they have a legitimate Complaint regarding the conduct of peace officers, employees, custodial officers including employee and contracted Health Care Providers, working under the direction of the Sheriff's Office or Probation Department, designated above. CLERB shall also make every effort to ensure public awareness of the seriousness of the process, and that fabricated Complaints will neither be tolerated nor reviewed. The statutory and constitutional rights of all parties shall be safeguarded during the review process.

BACKGROUND

In 1990, voters in San Diego County enacted a ballot measure to amend the County Charter requiring the County Board of Supervisors to establish the "Citizens Law Enforcement Review Board" ("CLERB") to independently investigate complaints against officers employed by the Sheriff's Office and Probation Department. CLERB is composed of eleven volunteers from the County's five supervisorial districts—two from each district and one serving at large. CLERB is currently supported by a full-time staff of twelve County employees, including an Executive Officer.

DUTIES AND RESPONSIBILITIES

Prepare reports, including at least the Sheriff or the Chief Probation Officer as recipients, on the results of any investigations conducted by CLERB in respect to the activities of peace officer, employees or custodial officers employed by the County in the Sheriff's Office or the Probation Department including any employee and contracted Health Care Provider including recommendations relating to any trends in regard to employees involved in Complaints. CLERB is not established to determine criminal guilt or innocence.

Prepare an annual report to the Board of Supervisors, the Chief Administrative Officer, the Sheriff and the Chief Probation Officer summarizing the activities and recommendations of CLERB including the tracking and identification of trends in respect to all Complaints received and investigated during the reporting period and present the annual report to the Board of Supervisors within 60 days of its adoption by CLERB.

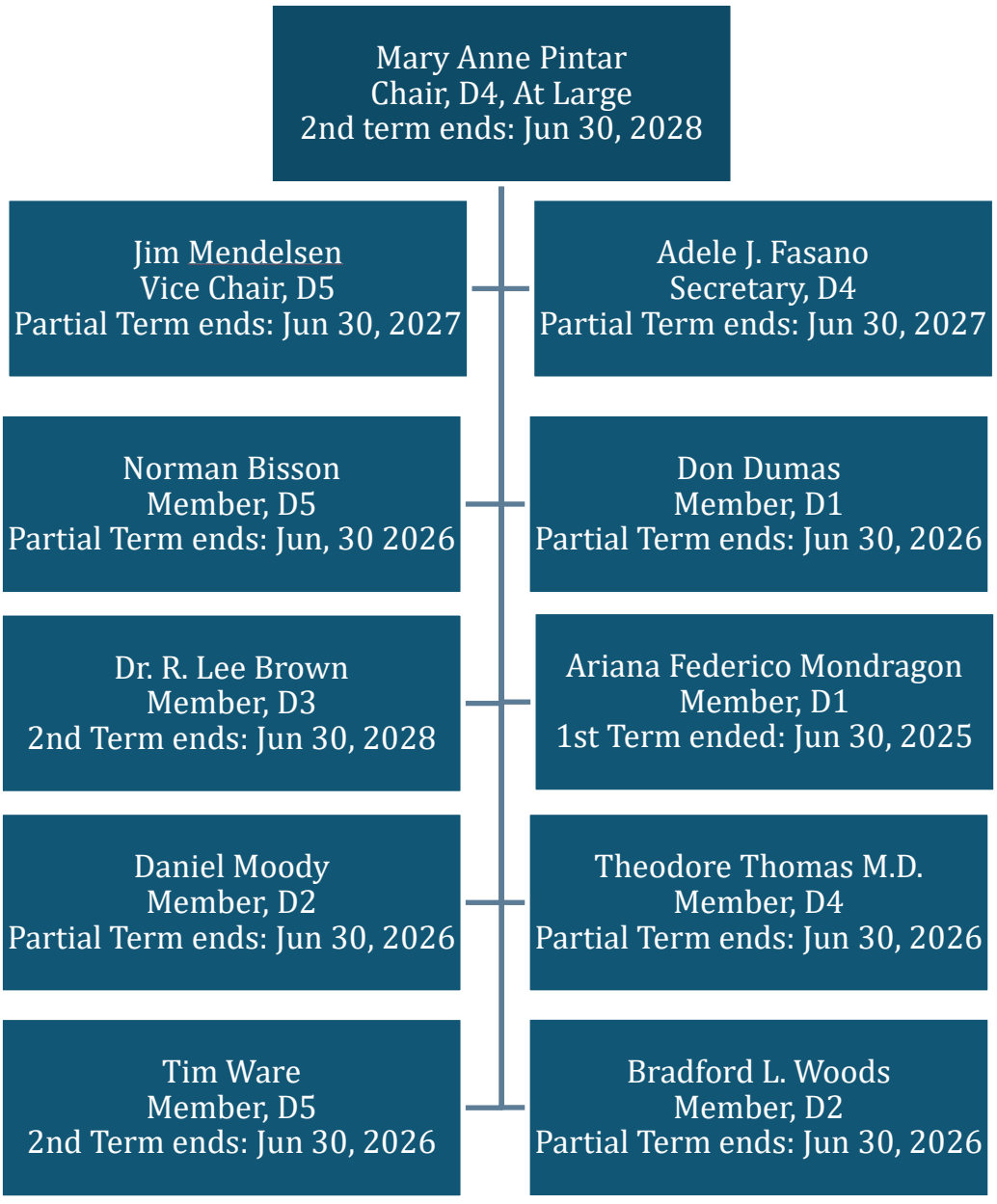
Review and make recommendations on policies and procedures of the Sheriff and the Chief Probation Officer to the Board of Supervisors, the Sheriff, and the Chief Probation Officer.

CLERB uses an "Investigative Model" for oversight. For background, there are three different types of oversight models: Review-focused, investigation-focused and auditor-focused. Agencies that fit within the investigative model employ professionally trained investigative staff to conduct investigations into allegations of misconduct independently of the overseen.

CLERB MEMBERS

Composition of CLERB. CLERB shall consist of 11 members nominated by the Chief Administrative Officer and appointed by the Board of Supervisors. Each CLERB member shall be a qualified elector of San Diego County and shall possess a reputation for integrity and responsibility and have demonstrated an active interest in public affairs and service.

Term of Membership. Each member shall serve a term of three years. A member shall serve on CLERB until a successor has been appointed. A member shall be appointed for no more than two consecutive full terms. Appointment to fill a vacancy shall constitute an appointment for one term. The term for all members shall begin on July 1 and end on June 30.



EXECUTIVE LEADERSHIP REPORT

2025 IN REVIEW

In 2025, the Citizens' Law Enforcement Review Board (CLERB) achieved notable progress under new leadership, implementing strategic structural and operational enhancements to reinforce its mission. Increased staffing prompted modest reorganization, with additional growth anticipated in 2026. The onboarding of six new Board Members that involved an orientation process, including detention facility tours, ride-alongs, and the implementation of a reformatted handbook. Despite transitional challenges and vacancies, CLERB remained steadfast in its commitment to conducting thorough and timely investigations. Operational improvements and additional personnel strengthened the Board's capacity to engage effectively with key stakeholders, optimize meeting preparation, and streamline workflows, ensuring continued organizational efficiency and accountability.

In February, a request was submitted to the Board of Supervisors for two key positions: a community outreach/communications staff member, and a policy and data analyst. These roles are essential for strengthening transparency and accountability by improving our ability to analyze data and share information with the public. Additionally, CLERB welcomed its first new board member in quite some time, marking an important step forward for the organization.

In March, staff created a CLERB Procedural Manual that provides a framework for CLERB staff. A separate CLERB Board Procedural Manual was also updated to reflect changes in the way CLERB has changed over the years. These manuals include roles and responsibilities, special investigator training, staff expectations, intake, investigations and assisting the Board for board meetings.

From April to August, CLERB added two Special Investigators and completed its 2022–2024 Annual Report, which the Board approved in August. During this period, CLERB participated in three Civil Service Hearings within one month and welcomed four new Board Members. Per County rules, Civil Service Hearings are afforded to peace officers who appeal Sustained finding(s).

In September, CLERB staff increased by two Special Investigators and an Administrative Assistant. Executive Officer Kalina gave a presentation to the Board of Supervisors on the effects of additional jurisdiction over medical staff in detention facilities. Chair Pintar also provided public comment in support of the additional jurisdiction. On September 30, the Board of Supervisors approved an ordinance related to the expansion of CLERB's jurisdiction over in-

custody death investigations to include Sheriff and Probation employees and contractors, such as Health Care Providers.

In October, the new jurisdiction regarding in-custody deaths went into effect on October 31, 2025. The new jurisdiction resulted in an increase in staff (two positions) and funds for health care experts.

In November, Chair Pintar, Executive Officer Kalina and a special investigator attended the 2025 Annual NACOLE Conference in Minneapolis. Supervising Special Investigator Lynn Setzler was promoted to Chief Deputy of Investigations. Chief Deputy Hakak continued as Chief Deputy of Operations.

In December, an offer of employment was made for an Outreach Specialist and a Data and Research Analyst. Both are scheduled to begin early January 2026. The remodel of the new office space has begun and is scheduled to be completed by the end of March 2026. The Board of Supervisors approved a new Board Member making a full eleven-person board for the first time in years.

ACCOMPLISHMENTS

Key accomplishments include:

1. Investigative Integrity: Investigators maintained a strong commitment to conducting thorough investigations. All investigations met the one-year statutory deadline even with new rigorous investigative protocols put in place in 2025.

2. Operational Efficiency: CLERB developed a comprehensive procedural manual, which included a training section to ensure effective allocation of resources and to support staff onboarding and development. For investigators, case deadlines were moved earlier to provide the CLERB Board with more opportunities to review and defer cases, if more information was needed.

3. Operational Efficiency: During 2025, CLERB closed out 177 cases and opened 158 cases. This increase in case closure rates resulted in a lessened backlog and has resulted in being able to present the case to the Board before POBR deadline. By the end of 2025, cases were presented 98 days prior to POBR compared to an average of 86 for the entire year.

4. Operational Efficiency: During 2025, CLERB modified the language used to report findings for in-custody death investigations. Pursuant to Rule 16.2 of CLERB's Rules and Regulations, CLERB now adopts final findings related to in-custody deaths which are not contained in separate specific allegations. The "Adopted" findings prevented the need for the use of the finding, "Action Justified".

5. Operational Efficiency: Throughout 2025, CLERB staff modified the confidential investigative report and other forms to provide enhanced transparency, consistent formatting, mandated evidence collection and language consistency, key performance indicators and improved visual aids. The new reports have resulted in less pre-meeting consultation, increased transparency with board members and less time in closed session reviewing evidence.
6. Board Engagement: No Board meetings were cancelled in 2025. Staff and Board members collaborated effectively to ensure all meetings occurred as scheduled. We worked in collaboration with San Diego Sheriff's Office (SDSO), Division of Inspectional Services (DIS) and Probation Liaisons for regularly scheduling tours, trainings and presentations for staff and board members.
7. Board & Community Engagement: In the last half of 2025, CLERB Staff was able to procure the use of the County Administrations Center's Board of Supervisors chambers (Room 310) for monthly board meetings. The increased public capacity along with technological improvements have resulted in more efficient and effective meetings.
8. Community Engagement: In 2025, CLERB strengthened community engagement through participation in multiple events and conferences, fostering collaboration and public awareness. Monthly Board Meetings provided opportunities for the public to listen to the presentations and offer input on key topics, including probation, mental health initiatives, the Civil Service Commission, the Psychiatric Emergency Response Team (PERT), and SDSO Detention Services. See Community Engagement and Trainings below.
9. Community Engagement & Transparency: As part of CLERB's ongoing commitment to transparency and operational excellence, we successfully coordinated the annual participation of the County Sheriff and Chief of Probation in board meetings. During these sessions, the leaders provided a comprehensive overview to the CLERB Board and the public of the strategic enhancements currently underway within their various workforce and facilities. This initiative not only underscores our dedication to improving detention operations (juvenile & adult) but also reinforces our collaborative approach to informing and engaging the community on matters of public safety and law enforcement services. It gave the public an opportunity to hear directly from the Sheriff and Chief of Probation in person and provide public comments.
10. Secure Information Sharing: CLERB transitioned from paper-based confidential mail to a secure electronic platform, significantly enhancing document security and operational efficiency. This shift not only improved the speed and reliability of sensitive communications but also

resulted in cost savings by reducing expenses associated with printing, postage, and physical document handling.

DEATH AND PRIORITY CASES

During 2025, the CLERB Board reviewed thirteen (13) in-custody death cases and one (1) death involving a barricaded subject who committed suicide. Complete findings for all thirteen cases can be found in Appendix A.

Of the thirteen in-custody deaths, two were accidental (overdoses), three were homicide (two by other Incarcerated Person (IPs), one was by suicide and the remaining seven were natural deaths. In one case, 24-117, the Medical Examiner ruled the death a homicide due to lack of insulin.

Three death cases decided in 2025 occurred in 2022, nine in 2023 and two in 2024. For reference, of the twenty-two (25) remaining open investigations, all are from 2024 (11) and 2025 (14).

The overall findings of the Board for each in-custody death case (which usually cover proper classification, adequate safety checks and the deputies' emergency medical response were all adopted/Action Justified. There was one Sustained finding for intercom failure (unidentified deputies), one Sustained finding for failure to conduct 30-minute safety checks (unidentified deputies) and one Sustained finding for failure to properly document safety checks (although safety checks were confirmed on video). There were three Summary Dismissals for allegations against medical providers as CLERB lacked jurisdiction. There were multiple Not Sustained findings for allegations of a deputy's emergency medical response, failure to keep separate, drugs entering the facility and an inadequate body scan.

Only one in-custody death investigation resulted in policy recommendations. In 24-117, the CLERB Board made three recommendations to SDSO on 12-12-25 (response pending):

1. It is recommended that the San Diego Sheriff's Office (SDSO) clarify and align Detentions policy with MSD R.5 to ensure compliance and prevent deputies from being the sole decision-maker for medication refusal.
2. It is recommended SDSO institute the use of technology to monitor the health and safety of people in custody at San Diego detention facilities.
3. It is recommended SDSO designate incarcerated persons with Type-1 diabetes with a medical alert status that is clearly communicated to relevant sworn staff. Further, it is

recommended that the SDSO implement refresher training regarding the identification of signs and symptoms of diabetic emergencies.

In 2025, CLERB closed two Discharge of Firearm cases. In both instances the subjects who were shot possessed weapons and repeatedly disobeyed commands. Both subjects were treated at hospitals and released.

In 2025, CLERB closed two Use of Force/Protest cases. Both cases originated in 2024. One was the encampment at UCSD in relation to the Israeli/Gaza conflict. The other was a protest of a motorcade containing Vice President Kamala Harris. In both cases, no serious injuries were reported or discovered, and all use of force was deemed Action Justified.

In 2025, CLERB closed 36 Use of Force Resulting in Great Bodily Injury cases. Fifteen (15) GBI cases were summarily dismissed because the case was either sealed or the Juvenile Judge determined there was no jurisdiction. In all the Use of Force cases, only one was Sustained for Excessive Force. The remaining cases were either Action Justified, Not Sustained or Unfounded.

POLICY RECOMMENDATIONS

In addition to the three policy recommendations for the in-custody death case above (24-117), CLERB made two additional policy recommendations to SDSO in 2025 which are still outstanding:

1. It is recommended that the SDSO update DSB P&P N.1, Grievance Procedures, by separating the "Personnel Complaint" investigative requirements for clarity.
2. It is recommended that the San Diego Sheriff's Office (SDSO) update SDSO P&P 6.131 Body Worn Cameras to include additional options for documenting reasons for muting, such as contemporaneous verbal statements.

In 2025, CLERB received eleven (11) responses from SDSO on outstanding policy recommendations dating from February 2024 to July 2024. See Appendix C for all Policy Recommendations received during 2025.

ONGOING PROJECTS

CLERB continues to advance several key initiatives:

Worked with Department of Purchasing and Contracting to procure a Request for Quotation (RFQ) to secure Medical Subject Matter experts for medical record review for in-custody death cases.

Procurement of a new Case Management system to provide better analytics and transparency.

Relocation at the County Administration Center building to accommodate growing staff is expected in spring, 2026.

In-Custody Death Data Study: The final report is targeted for release in 2026.
Enhanced Data Analytics: Ongoing efforts to improve data collection and reporting will help identify patterns and support better decision-making.

A new communication plan to better conduct enhanced outreach and better communicate the work of the CLERB Board.

CHALLENGES

Changes to Juvenile Probation cases: CLERB's ability to investigate individual Juvenile Probation cases now depends on authorization from a Juvenile Judge. Previously, a Standing Agreement allowed Probation to share case information with CLERB similar to the Sheriff's Office arrangement; however, Probation Counsel later determined this practice conflicted with state laws protecting juvenile confidentiality. After consultations with Legal counsel and Juvenile Court leadership, a new process was established requiring CLERB to file petitions for access to case files, with each petition reviewed by a Juvenile Judge to determine what records, if any, could be released. The first court order under this procedure was issued in October 2025. As a result, CLERB could not investigate Juvenile Probation complaints without judicial approval, and all 15 Summary Dismissed cases in 2025 were ruled outside CLERB's jurisdiction by Juvenile Judges.

CLERB staff participated in three Civil Service Commission hearings (mini trials) based upon appeals by Probation Officers and Deputy Sheriffs of the CLERB Board's Sustained findings. CLERB expended significant legal fees and staff hours.

Staff turnover: In 2025, CLERB staff welcomed four new Special Investigators and an Administrative Analyst. While CLERB staff was excited about the new additions, significant training was required which put additional strain on long-term employees and Executive staff.

Caseload: 2023 and 2024 produced the largest caseload in CLERB's history. As a result, those cases ended up being introduced to the CLERB Board in 2025. The high caseload contained numerous high priority cases including in-custody deaths.

Significant resources were expended on three long-running projects including a commissioned In-Custody Death Study; a new Case Management System and an office relocation at the County Administration Center.

A large majority of Sustained findings in 2025 were the result of failing to follow Body Worn Camera (BWC) policy, and more specifically for failing to properly record and failing to properly document instances of muting the BWC. CLERB attempted to address the misconduct by issuing a Letter of Concern to Sheriff Martinez on April 8, 2025, noting twelve (12) sustained findings for BWC issues. For the remainder of 2025, CLERB sustained an additional seven (7) times for BWC issues. SDSO responded by providing Training Bulletins reminding deputies of BWC policy.

COMMUNITY ENGAGEMENT AND CONFERENCES

Early this year, Chair Pintar and Executive Director Kalina co-presented at the International Visitor Leadership Program hosted by the San Diego Diplomacy Council, engaging with 26 global participants on Criminal Justice and Civil Society collaboration. In spring, the Executive Officer joined a Town Hall at Christian Fellowship Congregational Church alongside the Commission on Police Practices (CPP). In June, the Executive Officer participated in an online outreach event with the Board of State and Community Corrections (BSCC) In-Custody Death Board and Saving Lives in Custody. In November, Chair Pintar, Executive Officer Kalina, and a Special Investigator

attended the 2025 NACOLE Annual Conference in Minneapolis—an excellent opportunity to network and learn from other civilian oversight bodies nationwide.

TRAINING AND TOURS

The Board members and staff received several trainings in person and tours including:
SDSO Training Facility, East Miramar Range Complex (01-18-25)
San Diego Central Jail Facility Tour (05-22-25)
Vista Detention Facility (05-27-25)
South Bay Detention Facility Tour (05-28-25)
George Bailey Detention Tour (06-27-25)
The Commission on Peace Officer Standards and Training (POST) Decertification Process Workshop (08-12-25 and 08-29-25)
East Mesa Juvenile Detention Facility Tour (08-19-25)
Annual NACOLE Conference, Minneapolis (10-26-25 – 10-30-25)
San Diego Central Jail Facility Tour (11-13-25)
George Bailey Detention Facility (11-13-25)
Vista Detention Facility (11-20-25)
Las Colinas Detention and Re-Entry Facility (11-20-25)
Paradise Valley Hospital Tour (12-15-25)

2026 GOALS

These staff-driven goals align with County-wide benchmarks, including:

Communication Strategy: Develop and implement a concrete plan for 2026 that will provide CLERB guidance to strategically expand its public outreach, transparency and mission as well as increase public knowledge of CLERB. This will include updating the website, dissemination of public FAQs and utilization of our outreach County resources and social media platforms.
Enhance Policy Process: A comprehensive study and documentation of policy recommendations, past and present.

Research Projects: The contract with our new case management system has been signed and we are working on the implementation of the system. Using new case management system in creating real-time dashboards with investigation information will eliminate the need for

monthly workload reports. We are nearing the completion of the final draft of the In-Custody Death Study produced by The Mountain Whisper Light.

Community Engagement: Develop a community engagement plan with key goals and objectives to increase CLERB's presence and relationship with communities, organizations and stakeholders across the county.

Recruitment, Hiring, and Retention: Strategically develop and implement specific actions, collaborating with the Department Human Resources, to address open positions and maintain staffing levels for effective service delivery.

Innovative Solutions: Assess County (or department) operations to identify programmatic areas that will benefit from operational efficiency improvements. Through efforts such as business process reengineering, embracing technology, and/or furthering sustainability efforts, implement at least one identified efficiency that 1) maintains or improves exceptional customer service and/or 2) results in quantifiable cost avoidance and/or direct cost savings.

Innovative Solutions: Incorporate a mechanism for the CLERB Board to have annual input on setting the overall goals for the upcoming year.

Innovative Solutions: Hire and collaborate with Health Care Experts to review in-custody death medical records. This first-in-the-nation authority to review standards of care and policies will provide additional transparency for CLERB, the Departments, the Board of Supervisors and the public.

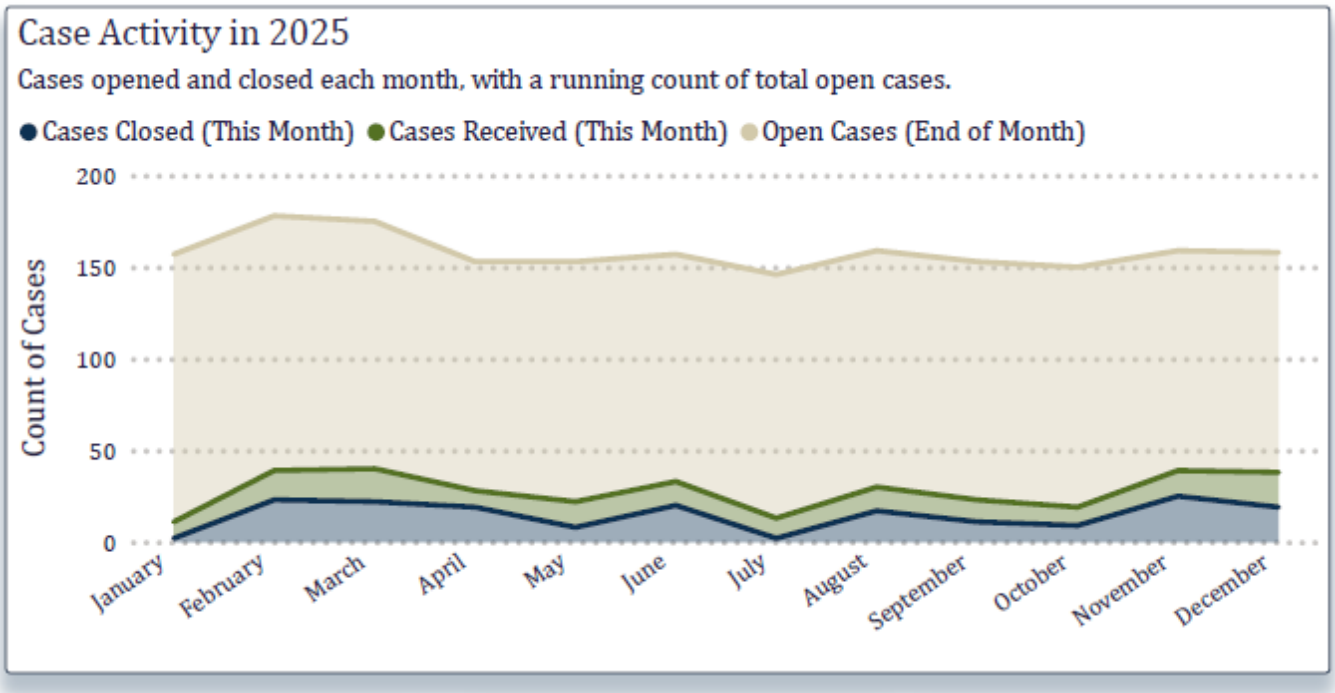
CONCLUSION

2025 marked significant milestones for CLERB. The Board achieved full membership, adding individuals with diverse backgrounds and expertise. A new cadre of Special Investigators joined, collectively providing 80 years of investigative experience. Budget enhancements funded critical positions to strengthen CLERB's mission of conducting independent, thorough, timely, and impartial investigations. These resources are essential to support our expanded jurisdiction over medical personnel in in-custody death investigations, which will be fully implemented in 2026. And most importantly, after many years of seeking additional jurisdiction over health care providers in death cases, CLERB realized the goal with the County Board of Supervisors amending an Ordinance and CLERB's Rules and Regulations to give that additional authority.

MaryAnne Pintar
Chair

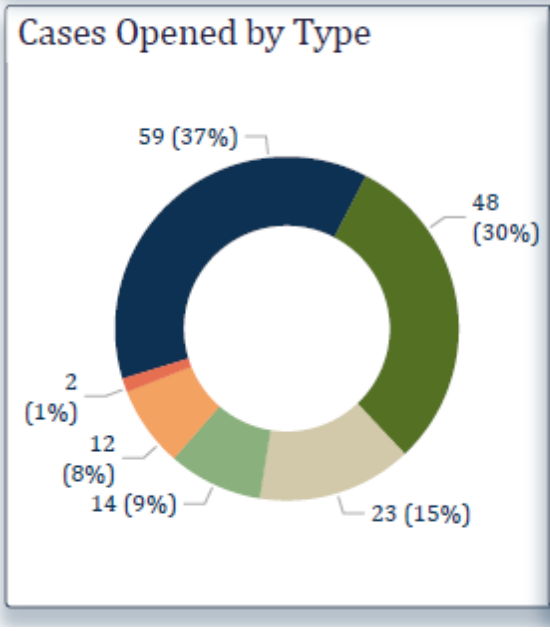
Brett Kalina
Executive Officer

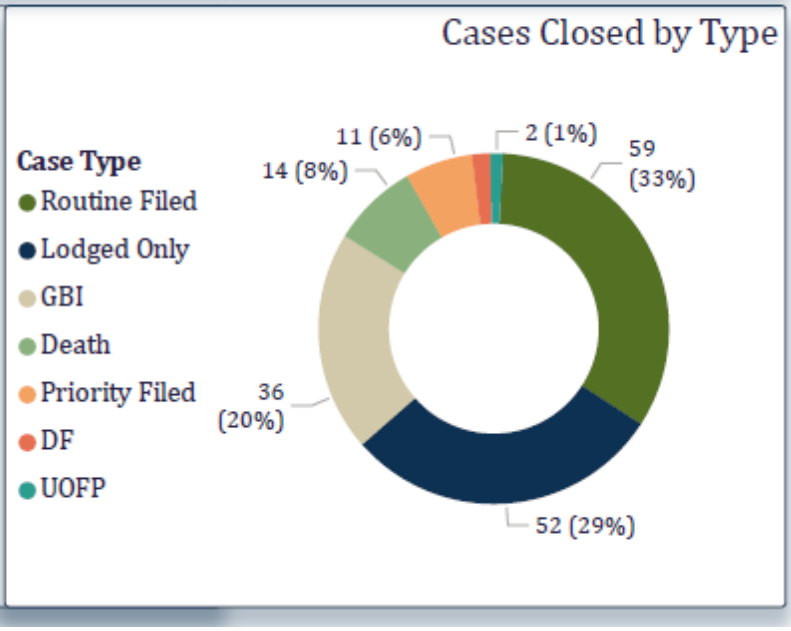
2025 STATISTICS



Opened Cases	Closed Cases	Timeliness*
158	177	86 Days Early

Timeliness measures the average number of days cases closed ahead of their due date.
**Procedurally Closed* cases are excluded from timeliness calculations because they do not reflect investigative performance.





CLOSED CASES

2025 Case Closure Highlights

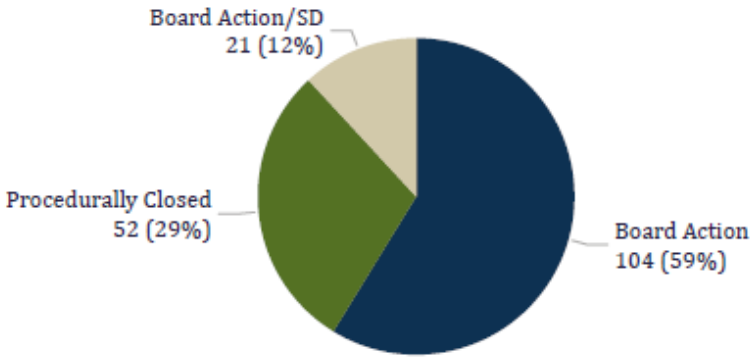
10
Regularly Scheduled Closed Session Board Meetings

12
Average number of Cases Closed Each Meeting

177
Total Closed Cases in 2025

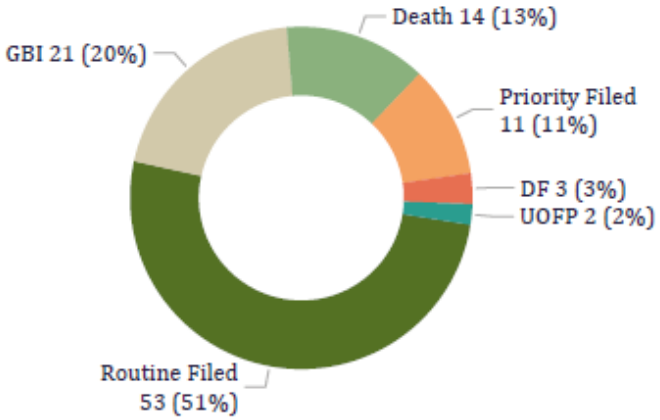
How did CLERB close cases in 2025?

Two-thirds of cases were closed by Board Action, meaning CLERB members deliberated and made case findings.



Types of Cases Closed by Board Action

Routine Filed cases made up over half of Board Action closures.



62% of cases closed by Board Action were Routine and Priority Filed complaints. A Complainant submits a complaint on behalf of themselves, or another party identified as the Aggrieved.

Summarily Dismissed Cases

GBI Complaints make up nearly three quarters of Summary Dismissed Cases.

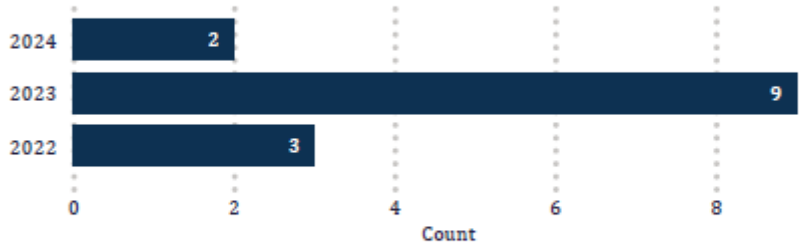
Cases may be Summarily Dismissed for several reasons with the most common being Jurisdiction. 15 Use of Force Resulting in Great Bodily Injury cases were dismissed due to being ruled out of CLERB's jurisdiction by Juvenile Court.

See more details in the Priority Cases review section.

CLOSED DEATH CASES

Death Cases by Year of Incident

Some death cases take year to close. In 2025, most deaths actually occurred in 2023.

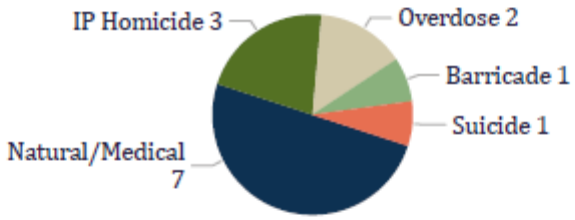


Death cases may take longer to close because they involve multiple layers of review. CLERB must wait for various records, which can take months or years, and any related criminal or civil investigations must be resolved before our review can conclude.

Natural deaths make up half of closed death cases in 2025. One case led CLERB to issue policy recommendations.

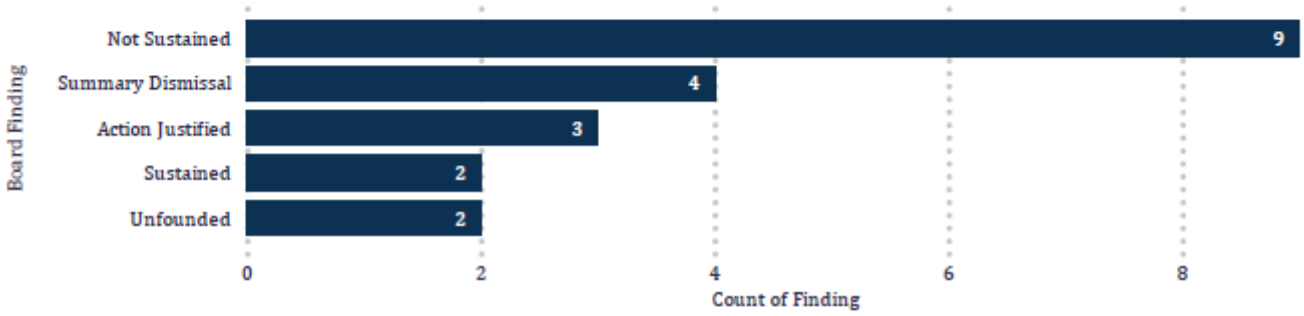
See Appendix A for the full recommendation.

Death Case Types



Board Allegation Finding

Deaths are Specified Incidents, which could include complaint allegations. See Appendix A for Finding definitions.

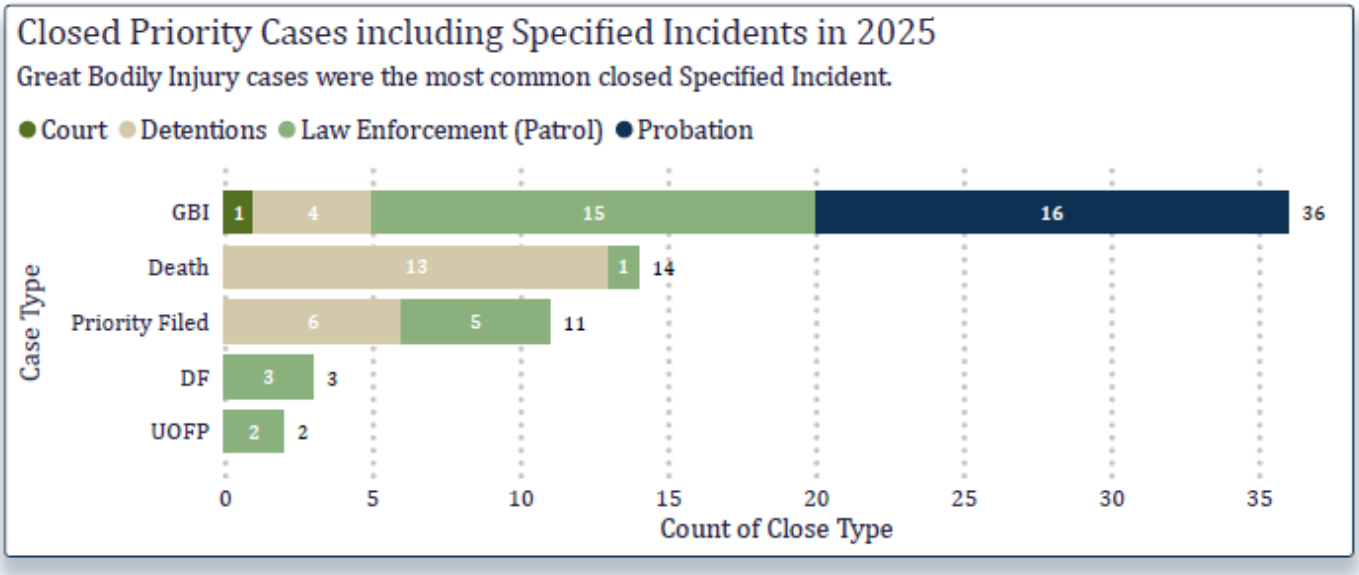


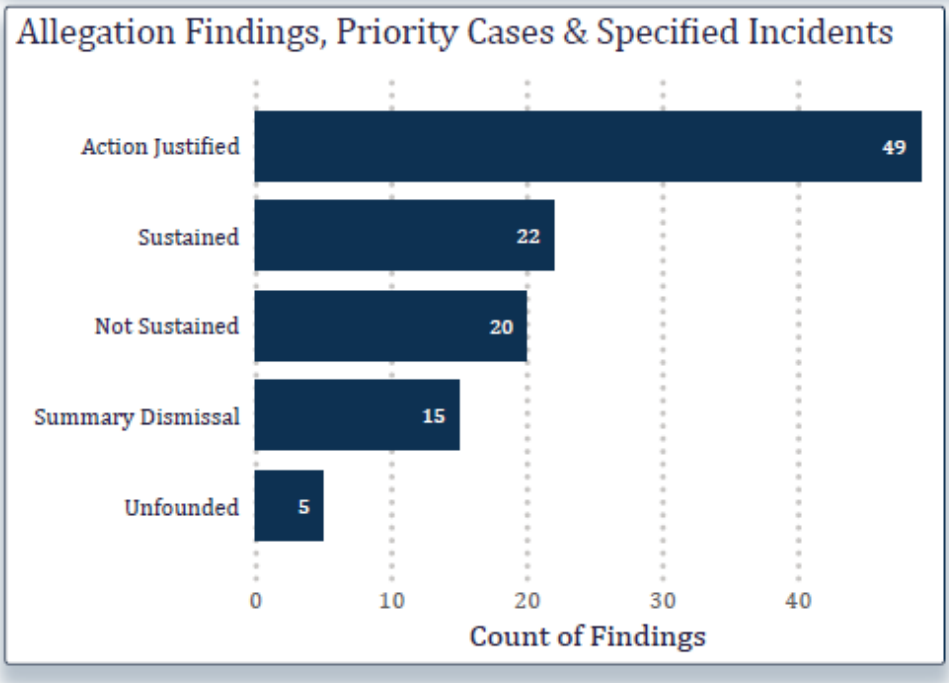
Death cases often involve multiple allegations, an average of **2.5 per case** in 2025. These allegations are in addition to the overall Death investigation. Misconduct/Procedure violations were the most common allegation type. This trend mirrors all CLERB cases, not just death cases.
Safety Check Violations were the most frequently violated procedure for 2025 death cases.

2.5
Average Number of Allegations per Death Case.

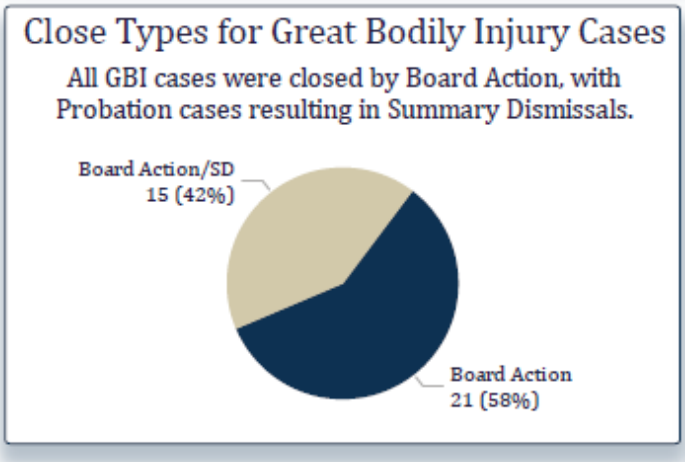
Safety Check Violation(s)
Sustained twice in 2025 Death Cases.

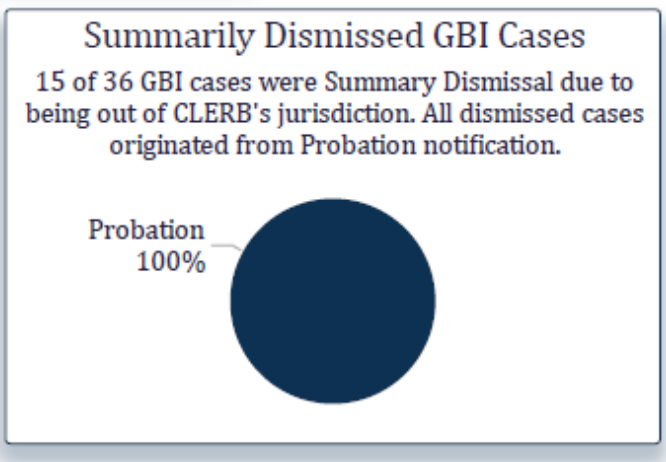
CLOSED SPECIFIED CASES & COMPLAINT CASES



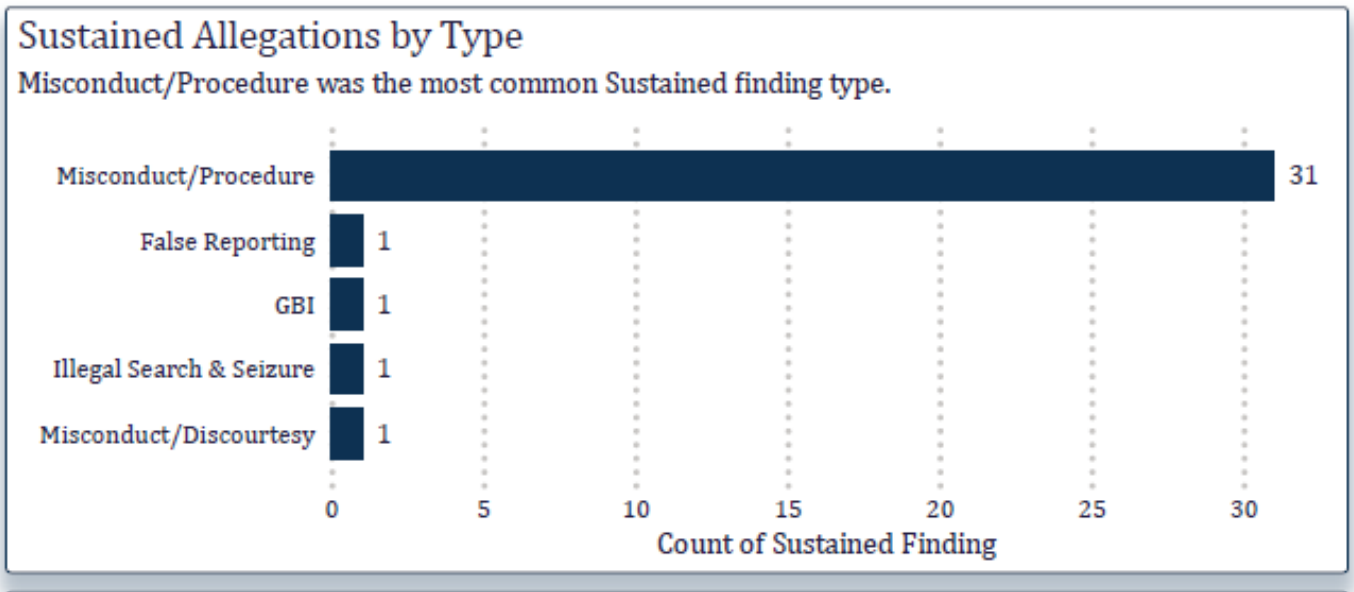


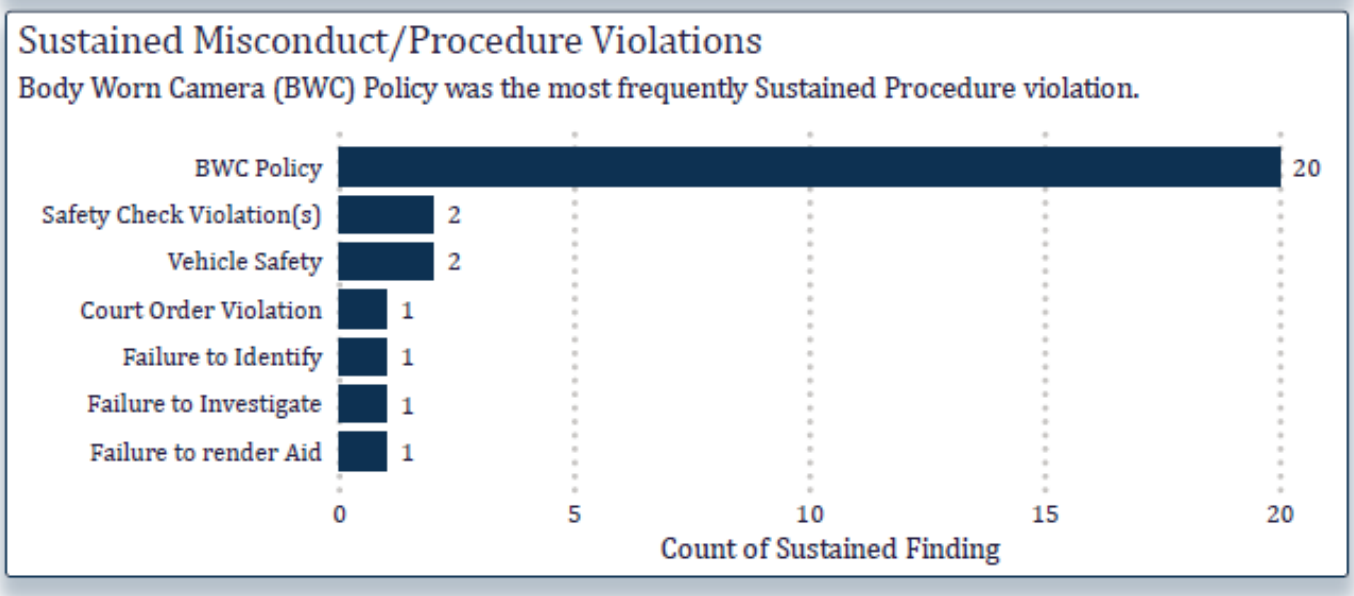
CLERB's ability to investigate Juvenile Probation cases depends on authorization from a Juvenile Judge.
In 2025, all 15 Summary Dismissed cases were Probation cases ruled outside CLERB's jurisdiction by Juvenile Court.
As a result, CLERB was not permitted to conduct investigations into these Specified Incidents.

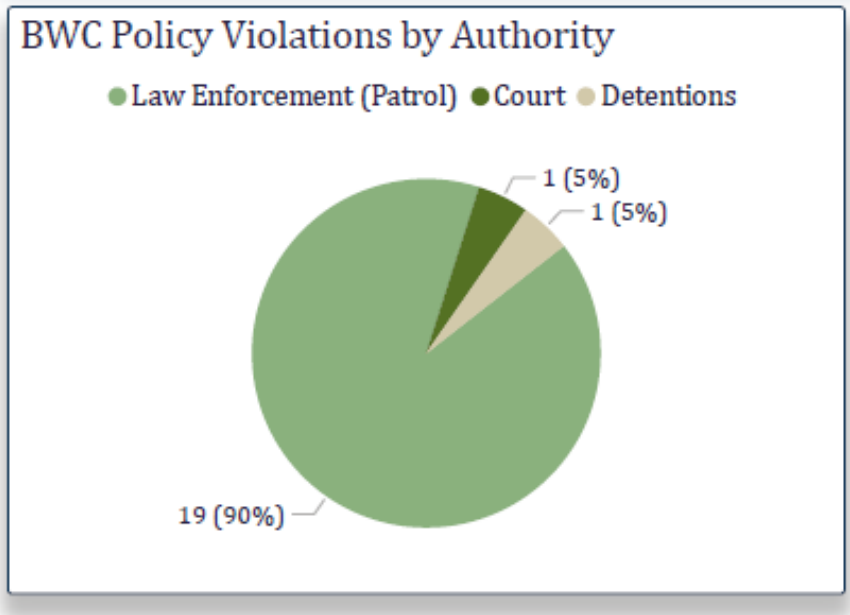




SUSTAINED ALLEGATIONS



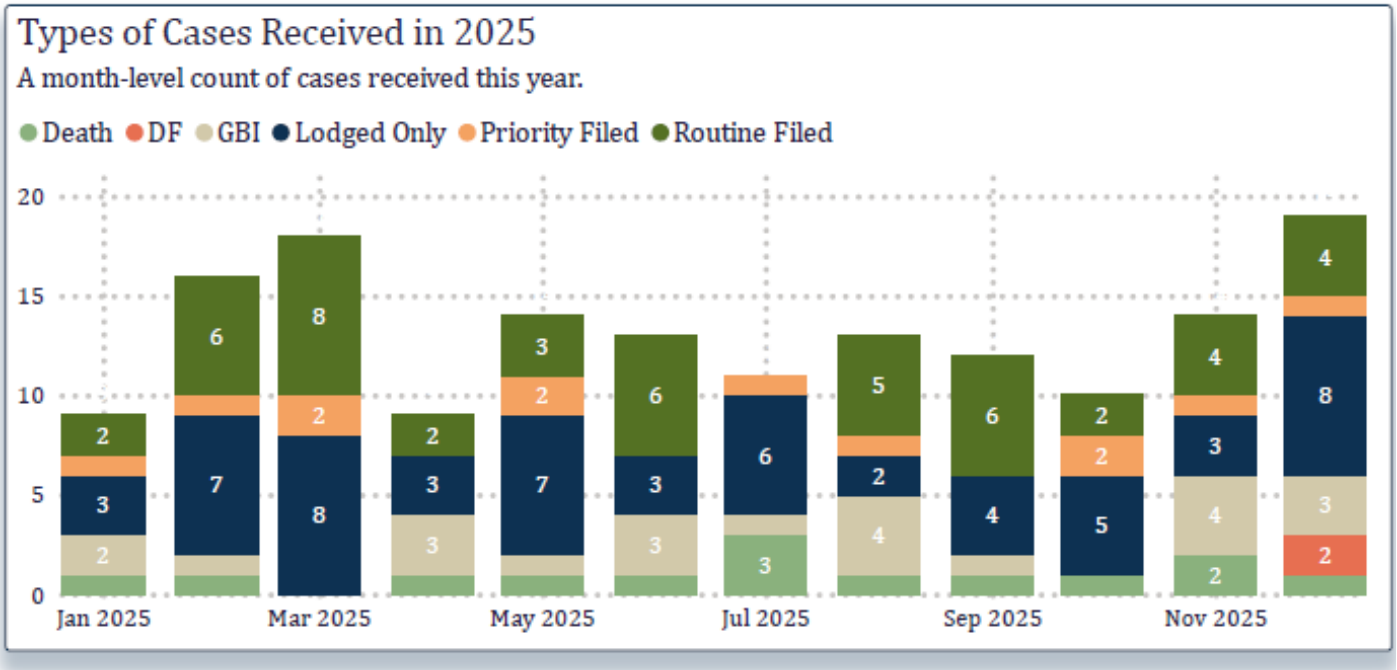




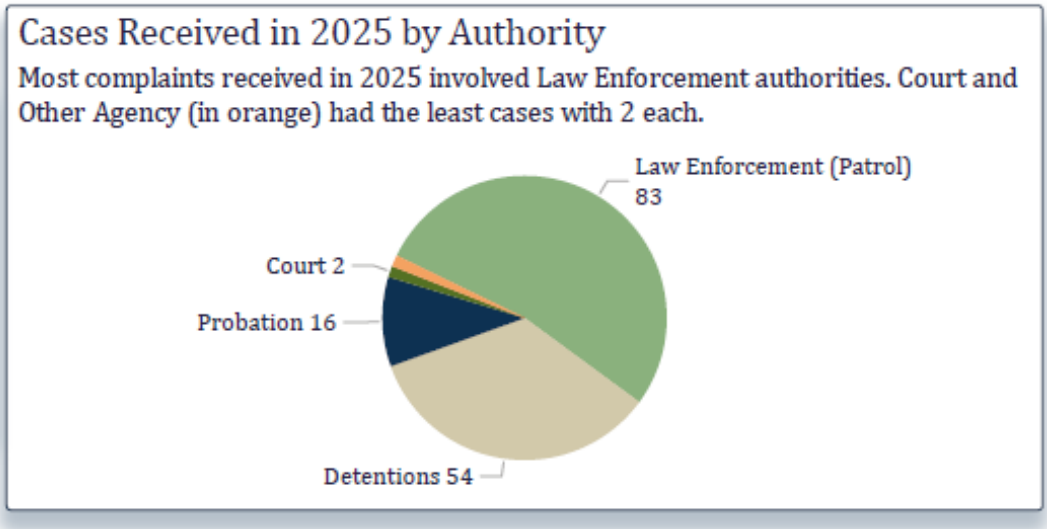
In 2025, nearly all Sustained BWC policy violations involved Law Enforcement (Patrol).

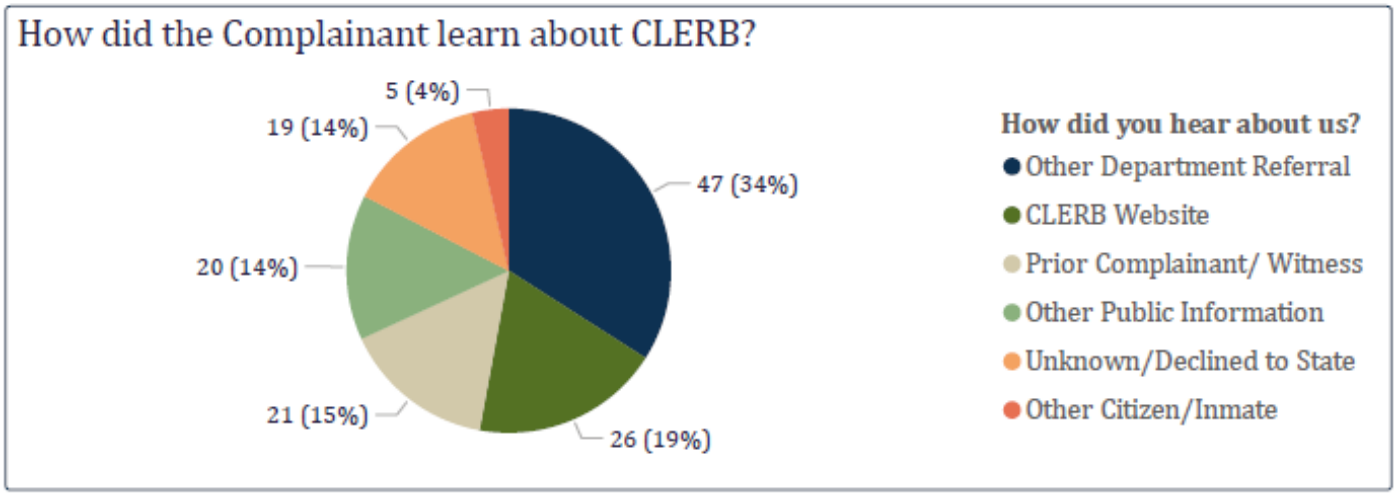
CLERB identified this recurring issue and, on April 8, 2025, issued a Letter of Concern to Sheriff Martinez citing twelve Sustained violations. By year's end, the total number of Sustained BWC violations grew to nineteen.

OPENED CASES

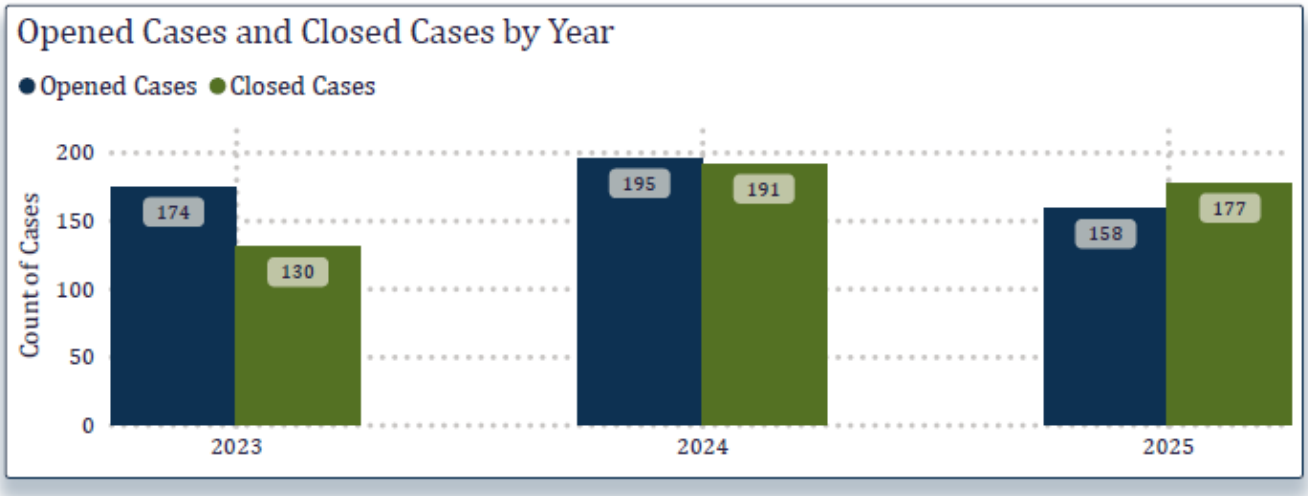


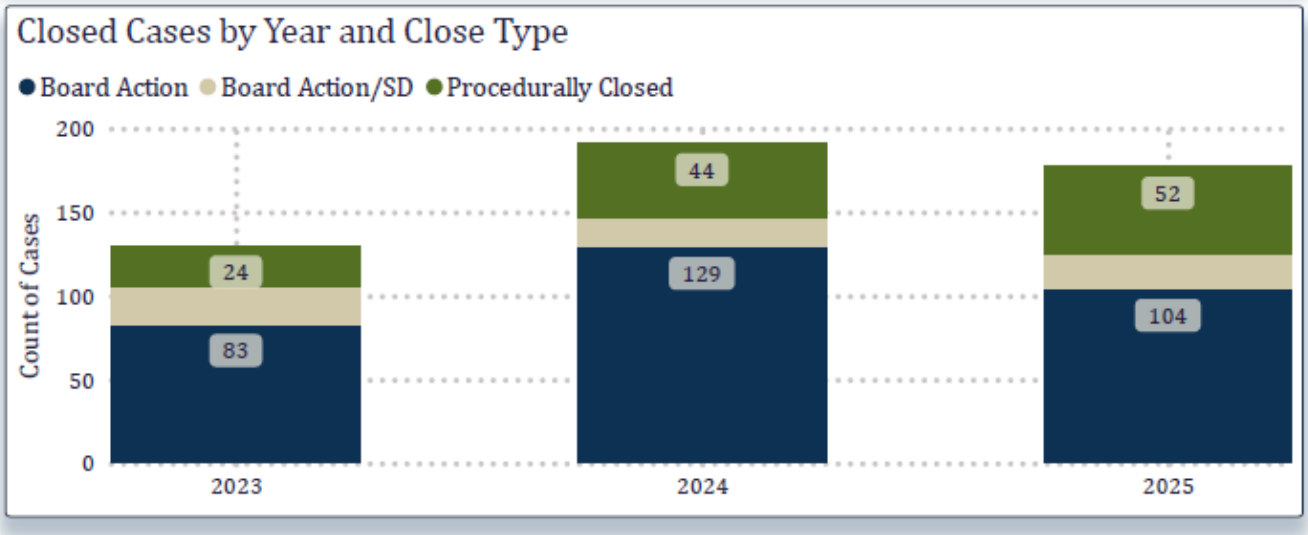
Staff screens each case for jurisdictional eligibility. CLERB's jurisdiction is defined per San Diego County's Administrative Code, Sec 340.

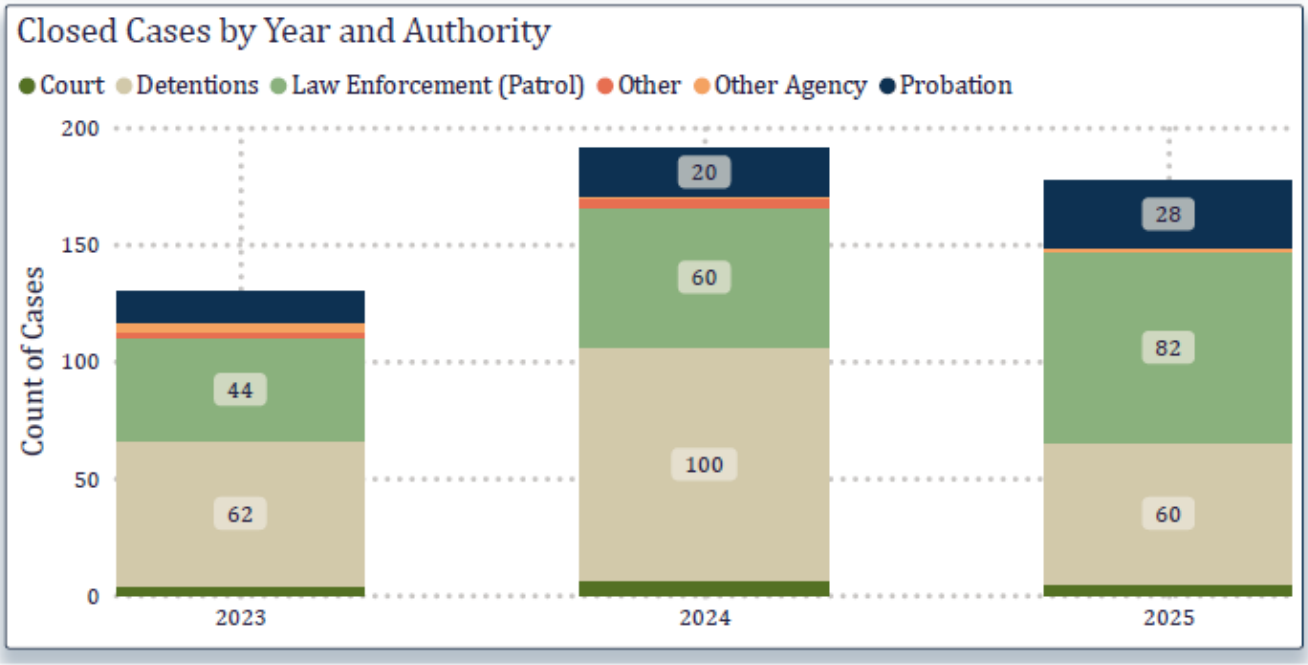




3-YEAR COMPARISONS

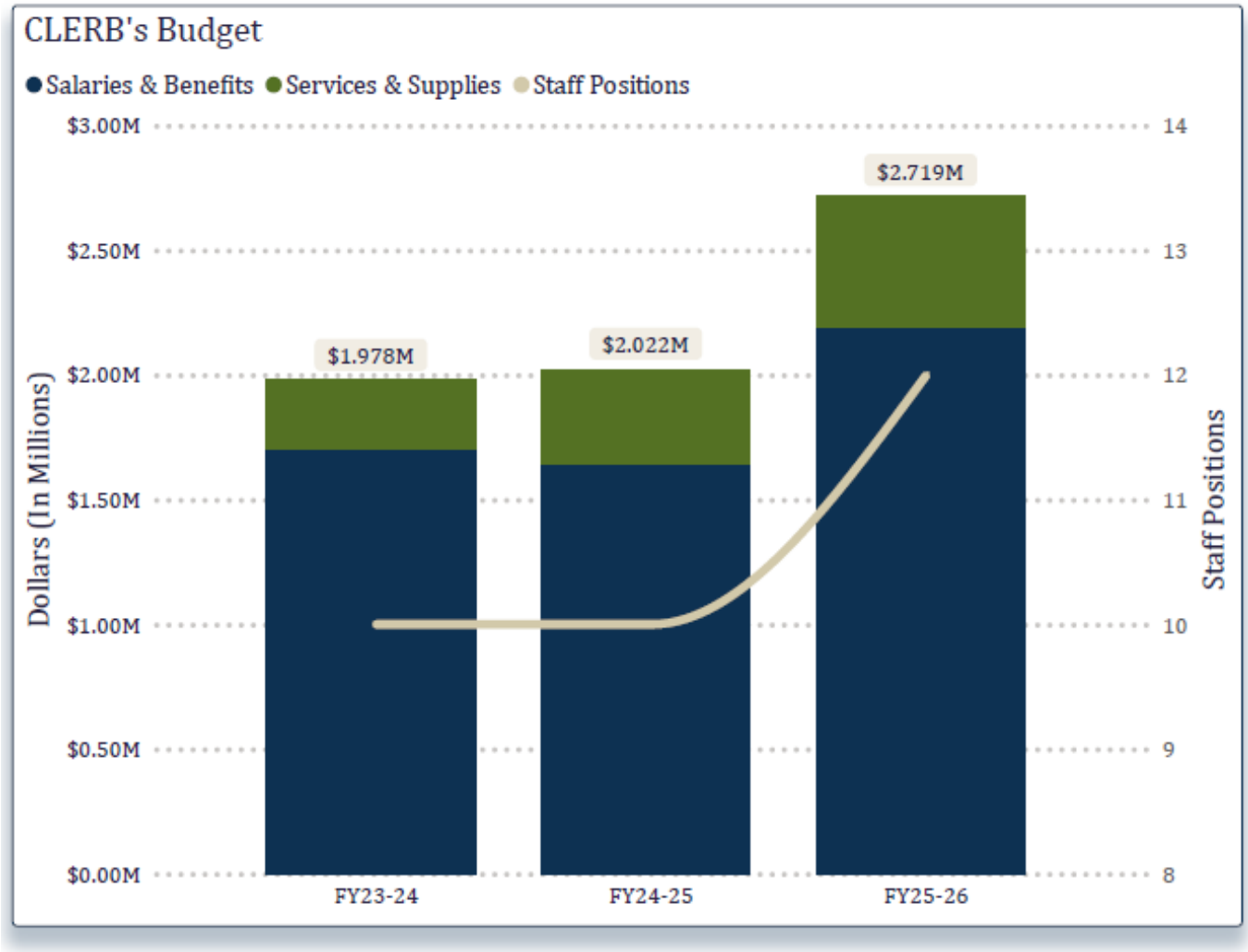






CLERB BUDGET

FY	Annual Budget	Salaries & Benefits	Services & Supplies	Employee Positions
FY23-24	1,976,018	1,701,031	276,747	10
FY24-25	2,021,071	1,811,956	209,115	10
FY25-26	2,718,935	2,188,427	530,508	12



- END OF REPORT -

- APPENDIX CONTINUES -

APPENDIX A: ABBREVIATIONS AND TECHNICAL TERMS

Abbreviations

This section lists all abbreviations used in the report along with their full forms. Entries are organized alphabetically for easy reference.

Board Action/SD: Board Action Summary Dismissal, these are cases that have been reviewed by CLERB and ultimately dismissed, likely for jurisdictional reasons.

BWC: Body Worn Camera.

Discharge of Firearm: These are cases reported to CLERB by SDSO and Probation which result in automatic jurisdiction, no complaint needed. This designation may be labeled in this report as "DF".

Great Bodily Injury: These are Use of Force resulting in Great Bodily Injury cases reported to CLERB by SDSO and Probation which result in automatic jurisdiction. This designation may be labeled in this report as "GBINC", "GBI".

IP: Incarcerated Person.

POBR: Peace Officer Bill of Rights.

Use of Force at Protest: These are cases that do not need to be reported to CLERB to trigger an investigation. This designation may be labeled in this report as "UOFP", "UOFPNC".

Technical Terms

Below are defined terms used in this report, please see CLERB's Rules and Regulations for the entire originating document.

"**Aggrieved Person**" Any person who appears from a Complaint to have suffered injury, harm, humiliation, indignity, or any other damage as a result of actions by a peace officer or custodial officer in the performance of official duties or the exercise of peace officer authority or employees, custodial officers including employee and contracted Health Care Providers, working under the direction of the Sheriff's Office or Probation Department.

"**Case**" A Complaint or investigation of an incident not requiring a Complaint.

"**Chair**" The Chairperson of CLERB or the Vice Chairperson if the Chairperson is not able to preside.

"**CLERB**" The 11 member Citizens' Law Enforcement Review Board nominated and appointed in accordance with the provisions of the Ordinance.

"**Complainant**" Any person who files a Complaint regarding the conduct of a peace officer or custodial officer in the employ of the Sheriff's Office or the Probation Department, including employee and contracted Health Care Providers in cases of in custody deaths or arising in the performance of official duties or the exercise of peace officer or custodial officer authority and who files a Complaint with CLERB.

"**Complaint**" A complaint received from any person without regard to age, citizenship, residence, criminal record, incarceration, or any other characteristic of the Complainant alleging an improper act or misconduct, as further defined in Section 4.1 of a peace officer or custodial officer in the performance of official duties or the exercise of peace officer authority. The complaint may consider the in-custody death of an individual alleging improper acts or misconduct, including standards of care against any employee or contracted health care provider working under the direction of the Sheriff or Probation.

"**County**" County of San Diego, California

"**Criminal Conduct**" Conduct punishable under any applicable criminal law.

"**Filed**" The status of a Complaint signed under penalty of perjury.

"**Findings**" The Final Report of CLERB shall contain an overall finding as to each allegation of the Case in the following manner:

a. If the investigation clearly established that the allegation is not true, the Finding shall be "**Unfounded**."
b. If the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation, the Finding shall be "**Not Sustained**."
c. If the investigation shows the alleged act did occur but was lawful, justified, and proper, the Finding shall be "**Action Justified**."
d. If the investigation disclosed evidence sufficient to prove the allegation by a Preponderance of the Evidence, the Finding shall be "**Sustained**."
e. If CLERB lacks jurisdiction or the allegation clearly lacks merit, the Finding shall be "**Summary Dismissal**."

"**Health Care Provider**" A person, whether employed by the County or as a contractor that provides medical or mental health care or treatment under the direction of the Sheriff's Office or Probation Department. Health Care Provider includes, but is not limited to, doctors nurses, nurse practitioners, midwives, optometrists, radiologists, pharmacists, psychiatrists, therapists, dentists, dental hygiene practitioners, and other professionals that provide such service in County detention facilities.

"**Lodged"** The status of a Complaint not signed under penalty of perjury.

"**Ordinance**" County Ordinance #7880, as amended, Article XVIII (commencing with Section 340) of the San Diego County Code of Administrative Ordinances adopted by the Board of Supervisors of the County of San Diego, California, which became effective on May 2,1991.

"**Preponderance of the Evidence"** Evidence that has more convincing force than that opposed to it.

"**Staff**" refers to the Executive Officer, Chief Deputies, Special Investigators, and Administrative employees of the County of San Diego.

"**Subject of Investigation**" Any peace officer, custodial officer, employee or contracted Health Care Provider of the Sheriff's Office or the Probation Department, working under the direction of the Sheriff's Office or Probation Department against whom a Complaint has been filed alleging improper or illegal conduct as set forth in Section 4.1 or about whom an investigation is undertaken without the filing of a Complaint as set forth in Section 4.3.

APPENDIX B: DEATH-CASE FINAL FINDINGS

This appendix provides the final findings for all death cases reviewed and voted on during CLERB meetings in 2025. Complete case findings are publicly available on CLERB's county website. To access them:

- Visit CLERB's homepage and navigate to the Meetings section.
- Scroll to Agendas & Meeting Records.
- Select the year you wish to view.
- Under each meeting, click the Final Findings link.
    - Additional documents are also posted in this section, including Agendas (available before meetings) and Workload Reports, Meeting Attachments, and Minutes (posted after meetings).

About the Cases Included

Each case listed in this appendix involves a death, but the circumstances vary widely. Cases may differ in the number of allegations, type of death, individuals involved, and CLERB's jurisdiction over those individuals. Each case is reviewed and voted on individually by Board members, and voting records are also available on the website.

Note on Terminology: In 2025, CLERB updated the language used for death-case findings.

- Meetings before August used the term "Action Justified" when the Board agreed the findings in the report.
- Meetings from August through December used "Approved."
- Beginning in 2026, the term will be standardized as "Adopted."
- All three terms indicate the Board's agreement with the overall death finding, which usually included classification, safety checks and emergency medical response unless noted in a separate allegation.

02-06-25

23-070/DAVIS (Death)

Death Investigation/In-Custody Medical – Zeke Samuel Davis died while in the custody of the Sheriff's Office on 07-08-23.

Board Finding: Action Justified

Rationale: Zeke Samuel Davis was booked into the Vista Detention Facility by Oceanside Police Officers on 06-29-23. During the booking process, Davis complained of illness. Davis was transferred to a local hospital for further medical evaluation. Davis was placed in the Hospital Guard Unit in compliance with Sheriff's P&P Section 6.46, Guarding Hospitalized Inmates. While at the hospital Davis's health continued to decline until 07-08-23, when Davis was pronounced deceased. The autopsy report stated, "Based on the examination findings and the circumstances surrounding the death, as currently understood, the cause of death is complications of invasive laryngeal squamous cell carcinoma, and the manner of death is natural." A review of evidence revealed no misconduct. The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.

03-06-25

22-106/BAGDASARIAN (Death)

Death Investigation/Barricade – William Bagdasarian set fire to his unattached garage and was later discovered by deputies with a self-inflicted gunshot wound on 08-19-22.

Board Finding: Action Justified

Rationale: On 08-19-22, deputies were dispatched to a 911 call reporting William Bagdasarian starting a fire in the garage and making suicidal threats. No one else was inside the home. Deputies attempted to first contact Bagdasarian prior to the Bomb/Arson Unit sending in an unmanned robot to confirm Bagdasarian was deceased. An autopsy determined the cause of death to be a perforating gunshot wound of head and the manner of death was suicide. Toxicology testing detected the presence of cannabinoids in his blood. There was no evidence of foul play. A family member provided consent for SDSO to enter the residence. Deputies were in compliance with SDSO policies for 6.38-Special Enforcement Detail (SED), 6.111-High Risk Entries, and 9.3-Crisis Negotiations. There was no evidence to support an allegation of procedural violation or misconduct on the part of Sheriff's Department sworn personnel.

22-136/BONIN (Death)

Death Investigation/In-Custody Medical – Incarcerated Person Aaron Daniel Bonin was found unresponsive in his cell at the San Diego Central Jail (SDCJ) on 10-24-22.

Board Finding: Action Justified

Rationale: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. Incarcerated Person (IP) Aaron Bonin was a 43-year-old white male, transferred from Patton State Psychiatric Hospital on 09-01-22, pending court proceedings for gassing a peace officer, assault with a deadly weapon, and battery on emergency personnel. Bonin was classified as a high-level, administrative separation, green banded IP who was housed on the 7th floor of SDCJ. Bonin had a long history of medical problems and was properly classified per DSB Policy R.1, which states an incarcerated person's initial classification is determined by their original booking charges, criminal history information, medical and psychiatric issues or additional special conditions, and information obtained from the incarcerated person interview. While in custody, Bonin was evaluated and treated for several documented medical and mental health concerns, which were identified upon his transfer from Patton State Hospital. Bonin was referred multiple times to local hospitals for acute care but was often non-compliant with his medications and treatment. On 10-24-22, video evidence and SDSO documentation confirmed that safety and security checks were completed in a timely manner, and at approximately 3:20am, Bonin was found unresponsive in his cell. Cardiopulmonary Resuscitation (CPR) was administered by deputies until an automated external defibrillator (AED) was utilized and 911 activated with fire personnel and paramedics responding to perform advanced cardiovascular life support for approximately 45 minutes prior to transport to a hospital. Bonin was intubated throughout his stay at UCSD Medical Center. His overall prognosis was poor and on 11-01-22, Bonin's family elected to compassionately extubate, and his death was pronounced. By a preponderance of the evidence, CLERB determines the investigation proved the actions taken were lawful, justified and proper.

1. Misconduct/Procedure - Unidentified deputies housed IP Bonin in a cell with an inoperable intercom and failed to conduct 30 minute security checks.

Board Finding: Sustained

Rationale: Through the course of investigation it was discovered that the intercom in Bonin's cell was inoperable on 10-24-22, following his medical emergency. SDSO records confirmed a maintenance work order was submitted on 09-13-22 for repair of the intercom in 7D, cells 8 and 9. Maintenance and repairs at the detention facilities are conducted by nonsworn personnel. Sheriff's records verified this order was completed on 09-15-22. Additionally, maintenance staff worked on the module intercoms going on and off from 09-19-22 until resolving the issue around 11-09-22. According to DSB Green Sheet, I.61.C.2, Safety Checks of Housing Units and

Holding Cells, dated 04-15-22, Sergeants assigned to the movement or security position will visually inspect each touchscreen once per shift to insure proper function. This will be documented in the notes section of the JIMS Supervisor Log Review entry. Maintenance and SDCJ administrative notification will be required for any intercom found not in working order. If an intercom is found not to be operable, the cell will be placed out of service until the intercom is fixed. 30-minute safety checks will be required if any incarcerated person is placed in a cell with an identified inoperable intercom and the watch commander will be immediately notified. SDSD personnel reported that IPs are routinely not placed into cells with inoperable communication systems. According to SDSO records, Bonin was placed into Cell09 on 09-25-22 with security checks conducted every 60 minutes. It could not be verified when Bonin's intercom became inoperable again following repair, or when/if 30 minute security checks were required. There was sufficient evidence to prove that unidentified deputies housed IP Bonin in a cell with an inoperable intercom and failed to conduct 30 minute security checks.

23-019/SHUEY (Death)

Death Investigation/In-Custody Medical – Incarcerated Person Robert Shuey was found unresponsive in his single person cell at San Diego Central Jail on 02-21-23.

Board Finding: Action Justified

Rationale: According to SDSO records, on 02-20-23, IP Shuey was involved in a motor vehicle accident in Oceanside. Shuey was transported to a hospital for evaluation and tested positive for COVID. Shuey was medically cleared and transported to San Diego Central Jail under suspected DUI charges on 02-21-23. Shuey was placed into a single occupancy room in the quarantine ward of the facility and placed on Alcohol Withdrawal protocol. Video evidence and SDSO documentation confirmed that safety and security checks were conducted, and while performing a routine welfare check at approximately 8:09pm, deputies found Shuey unresponsive and initiated cardiopulmonary resuscitation. Paramedics arrived on scene and despite resuscitative attempts, Shuey could not be revived, and his death was pronounced at the detention facility. No evidence of alcohol or illicit drugs was observed in the cell. The Medical Examiner's Office determined Shuey's cause of death was "cardiopulmonary arrest due to hypertensive atherosclerotic cardiovascular disease with cardiomegaly, with type II diabetes mellitus, SARS-COV-2 (COVID-19) infection, and chronic alcoholism as contributory factors, and the manner of death is natural." By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions taken by involved personnel were lawful, justified and proper.

23-046/ADAMSON (Death)

Death Investigation/In Custody Medical – Incarcerated Person (IP) Patricia Adamson experienced a medical emergency while housed at Las Colinas Detention Reentry Facility (LCDRF) on 05-03-23.

Board Finding: Action Justified

Rationale: Adamson was arrested by San Diego Police Department on 02-13-23 for vandalism charges and a probation hold. Upon booking, Adamson was classified as a Level 4-High Incarcerated Person (IP) and placed into a sobering cell. On 02-15-23, Adamson was transported to a hospital for vomiting and returned to custody a few days later. Adamson was housed in the Women's Psychiatric Stabilization Unit (WPSU) for a few months, until cleared and moved into an Outpatient Step Down Unit on 04-27-23. On 05-03-23 during a safety and security check at approximately 8:15 am, a deputy noted a "psychological decline" in Adamson and contacted medical for assessment. Medical arrived as deputies transported Adamson to the shower later that day. Deputies noticed the IP had blood around her mouth and 911 was activated. Deputies placed Adamson in the recovery position, who continued to throw up blood. Medical responded to the scene and performed life saving measures. Paramedics also arrived and continued life saving measures, but Adamson died on scene. An autopsy was performed and determined the cause of death was complications of hiatal herniation of the transverse colon with contributing factors of chronic obstructive pulmonary disease; hypertensive cardiovascular disease and the manner of death was natural. According to SDSO DSB P&P, Section M.5 Medical Emergencies, all facility staff shall be responsible for taking action in recognizing, reporting or responding to an incarcerated person's emergency medical needs. In any situation requiring medical response, emergency medical care shall be provided with efficiency and speed without compromising security. If the incarcerated person's condition is believed to be life threatening, sworn staff shall immediately notify on-duty health staff and provide basic life support (BLS) and/or first aid care. Pursuant to policy, Adamson was classified properly. Safety and security checks were also conducted within policy. By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

1. Misconduct/Procedure – Deputy 1 failed to respond to Adamson's medical emergency.

Board Finding: Action Justified

Rationale: On 05-03-23, Deputy 1 was assigned as the floor deputy in Adamson's module. Deputy 1 performed a safety and security check at 8:15am and stated Adamson had "declined psychologically." Deputy 1 contacted medical that morning and asked for an assessment. Later that day at approximately 12 pm, Deputy 1 entered Adamson's cell and witnessed when she emitted a brown substance from the side of her mouth, which was described as coffee grounds by the deputy. Deputy 1 escorted Adamson to the shower in a wheelchair. When deputies escorted Adamson to the shower, two medical staff personnel were already present in the module and aware that Adamson had thrown up earlier that day. Medical staff were waiting to assess Adamson when she had the medical episode and additional medical staff responded. According to SDSO DSB P&P, Section M.5 Medical Emergencies, all facility staff shall be responsible for taking action in recognizing, reporting or responding to an incarcerated person's emergency medical needs. In any situation requiring medical response, emergency medical care shall be provided with efficiency and speed without compromising security. Deputy 1 acted in accordance with policy, as she contacted medical that morning when she saw a concern with Adamson's mental/physical health. Also, SDSO DSB P&P, Section M.6 Life Threatening Emergencies: Code Blue states any life-threatening medical emergency shall trigger a 911 request for a paramedic emergency response team. In addition, health staff responding to a code blue shall manage the emergency response, monitor IPs status continuously and delegate as necessary. Deputy 1 responded in accordance with policy and procedure. By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

2. Misconduct/Procedure – Unidentified staff failed to sanitize Adamson's cell.

Board Finding: Not Sustained

Rationale: Complainant Paloma Serna alleged Adamson lived in "awful conditions" and a "filthy cell." Jail medical staff stated on 02-27-23 Adamson's cell was noted to be "extremely filthy with feces, and vomit on the floor and toilet seat" but the IP refused to change cells, and the IP was "too hostile" to continue cleaning the cell. Deputies would "take advantage" of Adamson's cooperation and would move her to a clean cell. Jail medical staff also stated Adamson's cell would become full of trash within one day and she often refused to cooperate with trash collection. Adamson was housed in House 5 for seven days, where she remained in cell #12. There was daily activity of Covid Cleanup/Disinfecting, which consisted of IP workers cleaning the common areas and picking up trash from cells. However, SDSO documentation did not show

that trash was collected from Adamson's cell. Per Body Worn Camera dated 05-03-23, Adamson's cell was in disarray, full of trash and had a brown substance on the floor, but it was unknown how long the cell was in that state. According to SDSO DSB LCDRF Green Sheets, Section L.2.L Sanitation and Hygiene Inspections states, absent exigent circumstances, weekly sanitation and hygiene inspections will be conducted throughout the facility on Friday nights. During hygiene inspections, deputies will ensure the cleanliness, safety and security, and maintenance of the cell/cubicle and housing area. If deputies are unable to enter the cell to complete a hygiene inspection, due to an IPs refusal to exit, the IP may be extracted at the direction of the watch commander. Adamson had a history of not cooperating with cell clean up and filling her cell with trash within a day's time. By a preponderance of the evidence, CLERB determines the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

3. Misconduct/Procedure - Unidentified staff failed to log a hygiene inspection at LCDRF.

Board Finding: Not Sustained

Rationale: Through the course of this death investigation, CLERB discovered a weekly hygiene inspection was not documented in the Jail Information Management System (JIMS), as mandated by policy. SDSO DSB LCDRF Green Sheets, Section L.2.L Sanitation and Hygiene Inspections, states, absent exigent circumstances, (emphasis added) weekly sanitation and hygiene inspections will be conducted throughout the facility on Friday nights. During hygiene inspections, deputies will ensure the cleanliness, safety and security, and maintenance of the cell/cubicle and housing area. In addition, a hygiene form will be completed for each module inspection and documented in JIMS under event type "Inspection." Although there was daily activity of Covid Cleanup/Disinfecting by IP workers, which included the cleaning of common areas and trash pickup inside of cells, this does not replace the mandated weekly hygiene inspections. The Watch Commanders Log dated 05-03-23 showed that all inspections were completed. By a preponderance of the evidence, CLERB determines the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

4. Misconduct/Procedure – Unidentified deputies failed to provide Adamson with a shower.

Board Finding: Unfounded

Rationale: Complainant Paloma Serna alleged, "We don't know how long she (Adamson) did not bathe." Adamson's medical records were reviewed and considered for the recommended finding. Title 15 Minimum Standards for Local Detention Facilities, Article 13, §1266. Showering states,

Incarcerated persons shall be permitted to shower/bathe upon assignment to a housing unit and at least every other day or more often if possible. SDSO DSB LCDRF Green Sheets, Section L.11.L Personal Hygiene states that offers to shower will be logged into JIMS in housing units where access to the shower is restricted. SDSO documentation verified that Adamson was offered showers while she was in WPSU in accordance with Title 15. Adamson often refused to shower, and it was unknown when her last shower occurred, but IPs in the module had dayroom/shower access on a daily basis. By a preponderance of the evidence, CLERB determines the investigation disclosed sufficient evidence to prove the allegation did not occur.

5. Misconduct/Medical – Unidentified staff failed to provide Adamson adequate medical care.

Board Finding: Summary Dismissal

Rationale: Complainant Paloma Serna alleged, "Medical staff decided not to treat or send Ms. Adamson out to the local hospital." Adamson was housed in Women's Psychiatric Stabilization Unit (WPSU) for the majority of her stay at LCDRF. According to SDSO MSD Operations Manual Section MSD.P.8 Psychiatric Stabilization Unit, a patient shall be admitted to the PSU upon the direct order of a Detentions Psychiatrist or the San Diego County Psychiatric Hospital. Patients admitted into the PSU shall meet the criteria as defined by the California Welfare and Institutions Code 5150 as an involuntary or a voluntary patient needing acute psychiatric care. All patients admitted to the PSU shall have an initial history and physical completed upon admission and access to medical care as needed. Adamson was properly classified/housed in specialized housing/WPSU where health staff are responsible for ongoing medical evaluation and treatment. CLERB Rules and regulations state that CLERB shall have authority to receive, investigate and report on complaints against custodial officers employed by the County in the Sheriff's Department. CLERB does not have jurisdiction over the subject matter of the complaint.

23-054/BARTOLACCI (Death)

Death Investigation/In-Custody Medical – Incarcerated Person Roselee Ann Bartolacci died while in the custody of the San Diego Sheriff's Office (SDSO) on 05-29-23.

Board Finding: Action Justified

Rationale: IP Bartolacci was incarcerated at the Las Colinas Detention and Reentry Facility (LCDRF) after her 04-06-23 arrest. Bartolacci was a psychiatric patient and housed alone in the jail's Psychiatric Stabilization Unit (WPSU/PSU). According to jail documents, safety/security

checks were performed in accordance with SDSO policy and procedures. According to SDSO DSB P&P Section I.64 titled "Safety Checks: Housing and Holding Areas of Incarcerated Persons," safety checks in the PSU shall be conducted at least once within every 30-minute time period. A review of safety checks noted all were performed within the 30-minute time period. At approximately 11:34pm, following a safety check by Deputy 2, Deputies 1 and 2 and a nurse entered the cell and found Bartolacci unresponsive, lying on her back, mouth agape, eyes open, and without a pulse. The nurse immediately initiated basic lifesaving measures by procuring an AED device and soon thereafter chest compressions with oxygen. Additional jail medical staff and paramedics were summoned to the scene. Upon paramedic's arrival on scene, they continued administering advance cardiac lifesaving measures until Bartolacci's death was pronounced. Bartolacci's cause of death by the San Diego County Medical Examiner's Office was determined to be "complications of dilated cardiomyopathy, with obesity being a contributing factor and the manner of death is natural." The evidence indicated Bartolacci was properly classified upon her entry into the SDSO jail system. There was no evidence that Bartolacci expressed any concerns for her mental or physical well-being to any member of the SDSO, sworn or professional. By a preponderance of the evidence, CLERB determines the investigation proved the actions taken were lawful, justified and proper.

1. Misconduct/Procedure – Deputy 1 failed to provide emergency medical care to Bartolacci.

Board Finding: Not Sustained

Rationale: While conducting a safety/security check on Bartolacci, a Nurse asked Deputy 1 to assist in entering Bartolacci's jail cell. Together, they found Bartolacci lying on her back, unresponsive, mouth agape, eyes open, blue lips and no pulse. The nurse exited the jail cell to retrieve an AED machine while Deputy 1 remained in the cell next to Bartolacci. The nurse returned with the AED in approximately 28 seconds and placed the AED pads on Bartolacci. Following the AED alerting to start CPR, Deputy 2 began chest compressions. SDSO DSB P&P Section M.5.B "Medical Emergencies," states, "When the severity of the medical emergency requires it, and as soon as it is safe to do so (unless death is obvious, such as decapitation, obvious rigor mortis, etc.), deputies acting as first responders will provide basic life support and first aid. Upon arrival, facility health staff will assess the severity of the person's injury/distress, provide first-aid, and may assist or take over cardiopulmonary resuscitation (CPR) responsibilities, until relieved by 911 personnel (paramedic emergency response team)." DSB

P&P Section M.6.B.4 titled "Life Threatening Emergencies," states, "Start cardiopulmonary resuscitation (CPR) as needed using a barrier device (e.g., PAM mask, pocket mask). Additional resuscitative equipment will be provided by health staff. Health staff will determine the appropriateness of utilizing additional emergency equipment including, but not limited to, the Automated External Defibrillator (AED). In circumstances, or locations, where response time from health staff may be delayed (e.g., the public visit lobby), a deputy may determine the appropriateness of utilizing additional medical equipment such as the AED." M.6.C states, "Health Staff responding to a code blue shall: Respond to the scene with the appropriate emergency equipment. 1. Assess the situation immediately. 2. Manage the emergency response and monitor the victim's status continuously. 3. Delegate as necessary. In addition to sworn staff, any health staff, including a medical doctor (MD), registered nurse practitioner (RNP), registered nurse (RN) or licensed vocational nurse (LVN) has the authority to call 911 or other medical transport for any medical condition they deem necessary. If health staff calls 911, notification shall be made to the watch commander or designee." When asked by homicide detectives if Deputy 1 provided medical aid, Deputy 1 responded, "no, I was waiting for the nurse to return with the AED." Deputy 1 also provided a confidential statement to CLERB that was considered in arriving at the recommended finding. While Deputy 1 did not begin CPR while the nurse retrieved the AED device as directed by policy, the policy also states the deputy is not the first responder when health staff are on the scene as M.5 and M.6 suggest. By a preponderance of the evidence, CLERB determines the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

23-080/MCDOWELL (Death)

Death Investigation/In-Custody Suicide – Incarcerated Person Jonathan Wesley McDowell, while in the custody of the San Diego Sheriff's Office, was discovered hanging in his cell on 07-19-23 and subsequently died at a hospital on 07-29-23.

Board Finding: Action Justified

Rationale: McDowell was under the custody of SDSO, incarcerated at the George Bailey Detention Facility (GBDF). On 07-19-23, at 9:45am McDowell underwent a routine medical welfare interview/evaluation by a Qualified Mental Health Practitioner and a sergeant. At the time of the welfare check, McDowell reported that he felt "fine." Approximately ten minutes later, at 10am, a housing deputy performed a safety/security check at McDowell's jail cell. McDowell was without complaint. At 10:18am, McDowell's cellmate alerted deputies of a "man down." Deputies arrived

at the jail cell and found McDowell unresponsive and hanging by a makeshift noose fastened around his neck. Deputies and jail medical/health staff performed life-saving measures. Paramedics were summoned and, upon their arrived, they took over life-saving attempts. McDowell was transported, to a local trauma hospital where he was diagnosed with a brain injury and was placed on life support. On 07-27-23, McDowell's family elected comfort care measures, and his health declined until his death, which was pronounced on 07-29-23. The evidence supported that McDowell was properly classified upon his entry into the SDSO jail system after his arrest. During his medical intake screening with SDSO medical personnel, to include psychiatric staff, McDowell never expressed suicidal ideations or intent. Upon being advised that McDowell was found hanging in his cell, sworn staff expeditiously responded and immediately initiated life-saving measures. The Medical Examiner's Office determined McDowell's cause of death was "Asphyxia due to Hanging," and the manner of death was Suicide. By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

05-01-25

22-124/VOGLEMAN (Death)

Death Investigation/Incarcerated Person Homicide - Raymond Vogelman, an incarcerated person in the custody of the San Diego Sheriff's Office, died on 10-05-22.

Board Finding: Not Sustained

Staff Recommended Finding: Action Justified

Rationale: This case was reviewed pursuant to CLERB Rules and Regulations, Section 4.3 Complaint Not Required: Jurisdiction with Respect to Specified Incidents. Evidence received from the San Diego Sheriff's Office (SDSO) showed on 10-05-22, Raymond Vogelman was in the custody of SDSO, housed at GBDF, when several incarcerated persons (IPs) began fighting in housing module 1A. Vogelman sustained injuries during the fight that required treatment by emergency medical personnel. Vogelman was transported to a local hospital where his health continued to decline. Vogelman was pronounced deceased on 10-05-22. Per the San Diego Medical Examiner's Report, "*…the cause of death is multiple blunt force injuries and the manner of death is homicide.*" During CLERB's investigation, it was noted that several physical altercations occurred at GBDF in housing module 1A, leading up to the 10-05-22 incident. It was also noted that on 08-03-22, in module 1A, Vogelman was assaulted in his sleep. An investigation conducted by GBDF detention staff was unable to determine who assaulted Vogelman. Following the 08-03-

22 incident, a deputy noted in an Incident Report, "*... He should not be placed back into Module A upon returning from the hospital.*" Between 08-03-22 and 08-10-22, Vogelman was housed at San Diego Central Jail (SDCJ). On 08-10-22, Vogelman returned to GBDF and was placed in module 1C. On 09-05-22, Vogelman was placed back in module 1A where he remained until the 10-05-22 incident. On 09-21-22, in module 1A, several IPs were involved in a fight which resulted in a 24-hour security lockdown. There were no other noted incidents in 1A leading up to the 10-05-22 incident. Vogelman had no restrictions that would have prevented him from being housed in module 1A, at the time of the 10-05-22 incident. SDSO Detentions Services Bureau P&P Section R.1, Incarcerated Person Classification, "*The Jail Population Management Unit (JPMU) will conduct classification assessments, assign individuals a classification, and assign housing for all incarcerated persons.*" It was also considered that IPs individual housing assignment can often change. The GBDF Floor Count Sheet for module 1A showed that none of the IPs Vogelman was immediately housed with at quad 201, on 08-03-22, were also housed with Vogelman in quad 101 on 10-05-22. ~~After reviewing the evidence, there was no policy violation associated with placing Vogelman back in module 1A.~~ By a preponderance of the evidence, CLERB determines the investigation proved ~~the alleged actions were lawful, justified and proper~~ there was insufficient evidence to prove or disprove the allegation that JPMU was notified per R.1. The CLERB Board directs the Executive Officer to create a policy recommendation.

1. Misconduct/Procedure – Deputy 1 recommended IP Vogelman not return to Module A, on 08-03-22.

Board Finding: Not Sustained

Staff Recommended Finding: Action Justified

Rationale: See Allegation #1. Following the 08-03-22 incident, a deputy noted in an Incident Report, *"... He should not be placed back into Module A upon returning from the hospital."* Between 08-03-22 and 08-10-22, Vogelman was housed at San Diego Central Jail (SDCJ). On 08-10-22, Vogelman returned to GBDF and was placed in Module 1C. On 09-05-22, Vogelman was placed back in Module 1A where he remained until the 10-05-22 incident. Vogelman had no restrictions that would have prevented him from being housed in Module 1A, at the time of the 10-05-22 incident. SDSO Detentions Services Bureau P&P Section R.1, Incarcerated Person Classification, "*The Jail Population Management Unit (JPMU) will conduct classification assessments, assign individuals a classification, and assign housing for all incarcerated persons. An incarcerated person's initial classification is determined by their original booking charges, criminal history*

information, medical and psychiatric issues or additional special conditions, and information obtained from the incarcerated person interview. The incarcerated person will be assigned to the most appropriate housing location based on their classification designation... Any employee who receives information that could change an incarcerated person's classification code and/or housing assignment has the responsibility of advising a JPMU deputy. The JPMU deputy will evaluate the information to determine whether it requires the incarcerated person to be reclassified. If it does, the reporting deputy may be asked to complete an Incarcerate Person Status Report detailing the relevant information..." CLERB evaluated if Deputy 1 advised the JPMU Deputy to not return Vogelman to Module 1A. Confidential responses submitted in Sheriff Employee Response Forms (SERF) were considered in making this finding. The evidence showed Vogelman did not initially return to Module 1A. Additionally, as noted in allegation #1, the GBDF Floor Count Sheet for Module 1A showed that none of the IPs Vogelman was immediately housed with on 08-03-22 were also housed with Vogelman on 10-05-22. ~~Based upon the available evidence, there is a preponderance of evidence that showed DSB P&P Section R.1 was followed~~. By a preponderance of the evidence, CLERB determines the investigation proved ~~the alleged actions were lawful, justified and proper~~ there was insufficient evidence to prove or disprove the allegation that JPMU was notified per R.1. The CLERB Board directs the Executive Officer to create a policy recommendation.

06-05-25

23-075/CARLTON (Death)

Death Investigation/Drug-Related – Incarcerated Person (IP) Timothy Aaron Carlton was found unresponsive inside of his cell while housed at San Diego Central Jail (SDCJ) on 07-20-23.

Board Finding: Not Sustained

Staff Recommended Finding: Not Sustained

Rationale: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. Timothy Aaron Carlton was a 53-year-old, white male. On 05-02-23 Carlton was arrested by the El Cajon Police Department and booked into San Diego Central Jail (SDCJ). Carlton was classified as a High/Level 5 Incarcerated Person (IP). On 07-20-23, Carlton moved housing units and was placed into House 5A at 5:09pm. At 5:24pm and 6:02pm deputies performed safety and security checks and looked inside Carlton's cell. At 6:58pm, a detentions deputy performed a safety and security check and noted

Carlton was unresponsive. The deputy opened the cell door, performed a sternum rub but did not get a response and called for medical. SDCJ Central Command Center then activated 911. Additional deputies arrived, pulled Carlton out of his cell and performed chest compressions. Medical arrived shortly after, took over the scene and continued with lifesaving measures to include chest compressions, Narcan, and oxygen. Paramedics also arrived and continued lifesaving measures. Carlton was pronounced deceased on scene. Detectives tested the intercoms and found them to be working properly. Following this incident, a witness stated Carlton offered them something that looked "like heroin" and stated Carlton "did whatever the hell it was" and "laid down." A white substance found inside Carlton's cell tested positive for fentanyl. An autopsy was performed, and the cause of death was determined to be acute fentanyl intoxication with other contributing conditions. Per DSB P&P Section M.6, Life Threatening Emergencies: Code Blue, any life-threatening medical emergency shall trigger a 911 request for a paramedic emergency response team. Sworn and health staff shall initiate emergency response and basic lifesaving measures until relieved by the paramedic emergency response team. In addition, health staff responding to a code blue shall manage the emergency response, monitor IPs status continuously and delegate as necessary. According to SDSO DSB P&P Section I.64, Safety Checks: Housing and Holding Areas of Incarcerated Persons, safety checks shall be conducted at least once within every 60-minute time period. In compliance with SDSO DSB P&P Section R.1 Incarcerated Person Classification, a review of the detention documentation showed that Carlton was classified correctly and there was no evidence that he expressed concerns for his safety by moving to Module 5A. Carlton was classified properly; safety and security checks were performed and deputies responded to the medical emergency in accordance with policy. Although a preponderance of evidence showed Carlton obtained the fentanyl in San Diego Central Jail, it is unknown how the fentanyl entered the facility and was provided to Carlton. By a preponderance of the evidence, CLERB determines the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

23-145/ALTMARK (Death)

Death Investigation/In-custody Medical – Incarcerated Person (IP) Donald Altmark was found non-responsive in the Hospital Guard Unit at Tri-City Medical Center on 11-12-23.
Board Finding: Action Justified
Staff Recommended Finding: Action Justified

Rationale: This case was reviewed in accordance with CLERB Rules and Regulations, Section 4.3 Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 08-09-23, Donald Altmark was arrested and booked into Sheriff's custody. Altmark was classified as 4-High Protective Custody/Advanced Age. On 10-26-23, Altmark was transferred to Vista Detention Facility (VDF) to be housed in an elderly IP special unit. Jail surveillance video showed upon arrival at VDF sally port (secured garage entrance), Altmark stepped off the transportation bus, stood up for about 1-2 seconds, turned his body and fell to the floor. Deputies responded to his aid and Altmark was transported to a hospital. A review of reports and video surveillance showed no mobility issues prior to the fall. Altmark was admitted into the Hospital Guard Unit at Tri-City Medical Center for several weeks and received treatment for his injuries. According to deputy reports, on 11-12-23 at 6pm Altmark was noted to be *"verbally responsive"* and at 6:35pm a deputy stated Altmark *"appeared to be asleep"* and *"saw his chest rise up and down."* According to deputy reports and hospital records, at 7:15pm a deputy and hospital staff member found Altmark *"not breathing"* inside his hospital room. Life saving measures were performed by hospital staff, but they were unsuccessful. A nurse was present and managed the emergency response. IP Altmark was pronounced deceased at 7:37pm. The cause of death was determined to be myocardial infarct due to hypertensive and atherosclerotic cardiovascular disease with other contributing factors. The manner of death was accident. Pursuant to DSB I.64.H, no "Code Blue" response is required of deputies in the Hospital Guard Unit. SDSO DSB – Hospital Guard Unit Green Sheet, Section I.64.H Safety Checks in Unit states, *"Whenever safety checks are conducted in the Hospital Guard Unit, the following shall be adhered to: A. Deputies are responsible for conducting intermittent safety checks of all the rooms, occupied or not, in the unit which are under the control of the San Diego Sheriff's Department. Safety checks will be logged in the Jail Information Management System by the Control Deputy. B. Deputies shall accompany all non-sworn personnel who enter a room where an inmate is present."* Although the safety and security checks were not logged into Jail Information Management System, deputy and hospital records showed deputies completed their safety checks. Per SDSO DSB P&P Section R.1 Incarcerated Person Classification, a review of the detention documentation showed that Altmark was classified as a 4-High, PC/Advanced Age. However, housing issues were not present because Altmark was never housed in VDF. By preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

1. Misconduct/Procedure – Deputy 3 failed to log safety and security checks in accordance with policy.

Board Finding: Sustained

Staff Recommended Finding: Sustained

Rationale: A review of the safety checks for Altmark was completed. On 11-12-23, Deputy 3 was stationed at the Hospital Guard Unit (HGU) at Tri-City Medical Center. Deputy 3 stated in an interview with SDSO detectives she was assigned as the control deputy the day of the incident and was responsible for *"making the logs."* HGU safety and security logs were not produced. SDSO provided information regarding the documentation of safety and security checks dated 11-11-23 to 11-12-23, "Deputies *performed their safety and security checks along with medical staff, but the checks were not logged into the jail information management system."* SDSO DSB Hospital Guard Unit Green Sheet, Section I.64.H Safety Checks in Unit, *"Whenever safety checks are conducted in the Hospital Guard Unit, the following shall be adhered to: Deputies are responsible for conducting intermittent safety checks of all the rooms, occupied or not, in the unit which are under the control of the San Diego Sheriff's Department. Safety checks will be logged in the Jail Information Management System by the Control Deputy. Deputies shall accompany all non-sworn personnel who enter a room where an inmate is present."* Although Deputy 3 separated from SDSO on 07-22-24, by a preponderance of the evidence, CLERB determines the investigation determined there is sufficient evidence to prove the allegation.

2. Misconduct/Procedure – Deputy 1 failed to review security logs.

Board Finding: Unfounded

Staff Recommended Finding: Unfounded

Rationale: See Rationale 2. According to SDSO deployment logs, Deputy 1 was assigned to the HGU on 11-12-23. Deputy 1 and SDSO Division of Inspectional Services (DIS) provided information during CLERB's investigation that was considered in arriving at the recommended finding. That information is privileged, per CLERB's agreement with the Deputy Sheriff's Association, and cannot be publicly disclosed. However, according to records from SDSO, Deputy 1 was not working on 11-12-23. According to the Vista Detention Facility Post Orders for Hospital Guard Unit Sergeant, the Sergeant's duties include: "Conduct daily supervisor rounds and JIMS Activity Log reviews." By preponderance of the evidence, CLERB determines the investigation determined the evidence shows the alleged act or conduct did not occur.

3. Misconduct/Procedure – Deputy 2 failed to review security logs.

Board Finding: Not Sustained

Staff Recommended Finding: Not Sustained

Rationale: See Rationale 2 & 3. According to witness interviews and corresponding reports, Deputy 2 was the acting Sergeant on 11-12-23 at the time of Altmark's death. SDSO provided information regarding the documentation of safety and security checks, dated 11-11-23 to 11-12-23, "Deputies performed their safety and security checks along with medical staff, but the checks were not logged into the jail information management system. According to the Vista Detention Facility Post Orders for Hospital Guard Unit Sergeant, the Sergeant's duties include: "Conduct daily supervisor rounds and JIMS Activity Log reviews." Deputy 1 and DIS provided information during CLERB's investigation that was considered in arriving at the recommended finding. That information is privileged, per CLERB's agreement with the Deputy Sheriff's Association, and cannot be publicly disclosed. By preponderance of the evidence, CLERB determines there was insufficient evidence to either prove or disprove the allegation.

24-004/WOLF (Death)

Death Investigation/Drug Related – Incarcerated Person (IP) Eric Alexander Wolf was found unresponsive in his cell at the San Diego Central Jail on 01-05-24.

Board Finding: Action Justified

Staff Recommended Finding: Action Justified

Rationale: Eric Alexander Wolf was incarcerated at the San Diego Central Jail since July 2023. Wolf was assigned to a jail cell with two other incarcerated persons (IP 1 and IP 2). IP 1 had been arrested less than 36 hours prior to Wolf's death. On the morning of 01-05-24, Wolf was found down and unresponsive in his jail cell. Deputies responded and initiated lifesaving measures, requested jail medical/health staff, and summoned emergency medical services. Paramedics responded to the scene and upon their arrival, they continued advanced cardiac life support measures. After vigorous attempts to revive Wolf failed, Wolf's death was pronounced on scene. An autopsy was performed on Wolf's body on 01-06-24 and the cause of Wolf's death was determined to be the toxic effects of fentanyl, and the manner of death was accidental. Wolf was classified as a security level four and was housed with inmates similarly classified pursuant to SDSO DSB Policy and Procedures (P&P) Section R.1. Jail records noted that on 01-05-24, safety checks were performed at 5:39am, 6:00am, and 6:56am, with the last check performed at

7:53am. Pursuant to SDSO DSB P&P Section I.64 "Safety Checks: Housing and Holding Areas of Incarcerated Persons," the safety checks were completed within a 60-minute window. Upon being discovered unresponsive, sworn personnel responded with speed and efficiency, and immediately initiated lifesaving measures pursuant to DSB SDSO P&P, Sections M.5 "Medical Emergencies" and M.6 "Life Threatening Emergencies: Code Blue. By a preponderance of the evidence, CLERB determines the investigation proved the deputy's actions were lawful, justified and proper.

1. Misconduct/Procedure – Deputy 1 failed to recognize an anomaly during IP 1's body scan.

Board Finding: Not Sustained

Staff Recommended Finding: Not Sustained

Rationale: Upon review of the evidence, it was alleged by an SDSO deputy that a subsequent review of IP 1's body scans from his intake on 01-03-24 showed an anomaly indicative of narcotics. Wolf's cellmate, IP 1, was booked into the SDCJ shortly before Wolf's death and was housed with Wolf approximately twelve hours before his death. During IP 1's intake, IP 1 participated in numerous searches, including pat down, body scans, medical review, x-ray and strip search. Deputy 1 provided information during CLERB's investigation that was considered in arriving at the recommended finding. That information is privileged, per CLERB's agreement with the Deputy Sheriff's Association, and cannot be publicly disclosed. Since the risk for IP 1 to be a narcotics carrier was high, he was put through a secondary screening process which included a pelvic x-ray. On 01-04-24, while placed in the 5th Floor Recreational Area awaiting cell placement, IP 1 was seen walking around and interacting with other incarcerated persons. At approximately 3:56pm, IP 1 was seen meeting up with another incarcerated person near the toilet area, out of sight from the deputies. Both IP 1 and the unknown incarcerated person are seen leaning over the sink. Once IP 1 left the sink area, another unidentified incarcerated person walked over to the sink, leaned over and walked away quickly. Approximately one hour later IP 1 was placed in a cell with IP Wolf. On the morning of 01-05-24, another deputy who heard the call of "Code Blue" in Module 5A began investigating the occupants of Wolf's cell. The deputy reviewed the body scans of IP 1 and noted an anomaly in the scans. The deputy stated, *"It appeared that [redacted] defeated the security measures in place and smuggled his contraband up to the 5th Floor*." The deputy returned to Module 5A and was the deputy who conducted a strip search of IP 1 following Wolf's death. IP 1 eventually produced a plastic bag from his anal cavity which IP 1 admitted was fentanyl. The narcotics eventually tested positive for fentanyl. IP 1 also

tested positive for fentanyl. Wolf's other cellmate, IP 2, tested negative for fentanyl. Although IP 1 admitted to bringing the fentanyl into the detention facility, he claimed he found it in a holding cell and also claimed he acquired it at the detention facility. According to SDSD DSB Section I.50 titled "Body Scanner and X-Rays, *The introduction and presence of unauthorized weapons, drugs and other contraband presents serious threats to the security and proper management of the detention facilities.* III.A. states: *body scan imaging technology is used to produce an image revealing the presence of contraband concealed on or inside a person. Body scans shall be completed as part of the Intake Search of persons. In the event an anomaly appears within a subject's body, the deputy conducting the scan will inquire with the arrestee to identify the anomaly.* Not only was IP 1 cleared from two body scans, but he was also cleared by two separate medical stages, secondary processing and a pelvic x-ray. By a preponderance of the evidence, CLERB determined there was insufficient evidence to either prove or disprove the allegation.

<u>24-107/VAN TINE</u> (Death)

Death Investigation/IP Homicide - Incarcerated Person (IP) Eric William Van Tine was assaulted while incarcerated at the San Diego Central Jail on 12-03-23.

<u>Board Finding</u>: Action Justified

<u>Recommended Finding</u>: Action Justified

<u>Rationale</u>: Incarcerated Person Eric William Van Tine was a 41-year-old white male who was incarcerated at the San Diego Central Jail (SDCJ). Van Tine was housed with two other incarcerated persons. On the afternoon of 12-03-23, a deputy was performing a safety/security check when he found Van Tine down and unresponsive in his jail cell, bleeding from a head wound. Jail medical staff were summoned and provided medical aid until paramedics transported Van Tine to a hospital. He was given a grim prognosis, and his health declined until his death on 11-08-24. Pursuant to interviews of Van Tine's cellmates, Van Tine had been involved in a physical altercation with IP 1 and was assaulted, including slamming Van Tine's head into the concrete floor. An autopsy was performed, and Van Tine's cause of death was blunt force injuries of the head, and the manner of death was homicide. Upon being found down and unresponsive in his cell, sworn personnel responded and immediately initiated life-saving measures until a medical emergency response team arrived. Per SDSO DSB P&P Section M.5 titled "Medical Emergencies," *all facility staff shall be responsible for taking appropriate action in recognizing, reporting or responding to an incarcerated person's emergency medical needs. In any situation requiring medical response, emergency medical care shall be provided with efficiency and*

speed without compromising security. If the incarcerated person's condition is believed to be life threatening, sworn staff shall immediately notify on-duty health staff and provide basic life support (BLS) and/or first aid care. According to SDSO DSB P&P Section M.6 titled "Life Threatening Emergencies: Code Blue," *any life-threatening medical emergency shall trigger a 911 request for a paramedic emergency response team. Sworn and health staff shall initiate emergency response and basic lifesaving measures until relieved by the paramedic emergency response team. In addition, health staff responding to a code blue shall manage the emergency response, monitor IPs status continuously and delegate as necessary*." A review of deputies' actions pertaining to housing, security checks and medical emergency responses was conducted. By a preponderance of the evidence, CLERB determines the investigation proved the deputies' actions were lawful, justified and proper.

1. Misconduct/Procedure – Deputy 2 housed IP Eric Van Tine with a "violent" cellmate (IP 1).

Board Finding: Action Justified
Recommended Finding: Action Justified
Rationale: Carole Van Tine reported, "*We request that you investigate the jail staff who housed Eric with someone who had a propensity for such violence*." Deputy 2 classified both IP 1 and IP Van Tine upon their arrival into the jail system. Van Tine was arrested for assault with a deadly weapon, threatening with intent to terrorize, and exhibiting a deadly weapon (not a firearm). On 12-03-23, Van Tine was classified as a security level 4-High. IP 1 was arrested for assault with a deadly weapon (not firearm), great bodily injury, vandalism of $400 or more, and assault with force with likely great bodily injury. IP 1 was classified as a security level 4-High. According to SDSD DSB P&P Section R.1 titled 'Incarcerated Person Classification,' *The Jail Population Management Unit (JPMU) will conduct classification assessments, assign individuals a classification, and assign housing for all incarcerated persons. An incarcerated person's initial classification is determined by their original booking charges, criminal history information, medical and psychiatric issues or additional special conditions, and information obtained from the incarcerated person interview. The incarcerated person will be assigned to the most appropriate housing location based on their classification designation.* By preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

2. Misconduct/Procedure - Deputies 1 and 3 conducted checks of IP Van Tine's cell.

Board Finding: Action Justified

Recommended Finding: Action Justified

Rationale: Carole Van Tine reported, "*We asked that you investigate if deputies properly monitor the cell by direct visual check and video feed*." On 12-03-23, safety/security checks were logged by deputies at 12:51am, 1:49am, 2:47am, 3:45am, 4:44am, 5:18am, 6:00am, 6:57am, 7:16am, 8:13am, 9:09am, 10:07am, 11:07am, 12:02pm, 1:00pm, 1:57pm, and 2:14pm. According to SDSO DSB P&P Section I.64, titled "Safety Checks: Housing and Holding Areas of Incarcerated Persons," *safety checks shall be conducted at least once within every 60-minute time period*. It should be noted there are no video feeds inside the cell. By a preponderance of the evidence, CLERB determined the investigation proved the alleged actions were lawful, justified and proper.

08-07-25

23-067/HEIMARK (Death)

Death Investigation/In-Custody Medical – Incarcerated Person Paul Arthur Heimark died while assigned to the Hospital Guard Unit at Alvarado Hospital on 06-26-23.

Board Finding: Approved

Conclusion: This case was reviewed in accordance with CLERB Rules & Regulations, Section 4.3 Complaint Not Required: Jurisdiction with Respect to Specified Incidents. Per CLERB Rules & Regulations 16.1, at the conclusion of a matter before the entire CLERB, CLERB shall deliberate and adopt a final report ("Final Report") with respect to the case or matter under consideration. This report shall include findings as to the facts relating to any case, as well as an overall conclusion as to any case as specified in Section 16.2 (Findings). On 06-14-23 Richard Heimark was arrested by SD County Probation per a court order and booked into San Diego Central Jail. During the medical screening process, Heimark was sent to 2nd Stage Medical and was cleared to continue the booking process. Heimark was treated for a respiratory concern and referred to higher level of care. Nursing staff requested Heimark be put into medical isolation and a physician's assistant determined Heimark needed to go to the emergency room. At 8:50pm, a nurse completed an Emergency Room Referral. Heimark was taken to the hospital and admitted at 9:47pm, for evaluation. Physicians determined Heimark needed acute care and admitted him into the Hospital Guard Unit (HGU). On 06-24-23, Heimark was transferred from the HGU to the ICU (Intensive Care Unit) unit for observation. On 06-26-23, Heimark experienced a medical emergency and despite lifesaving measures, Heimark was pronounced deceased at 8:55pm. The

San Diego County Medical Examiner's office determined the cause of death was pneumonia and the manner of death was natural. In compliance with SDSO policies, Heimark was transported to a hospital for evaluation and continued care until his death. A review of all known evidence revealed no policy or procedural violations on the part of sworn personnel.

11-06-25

23-117/BACH (Death)

Death Investigation/Incarcerated Person Homicide – Incarcerated Person (IP) Kenneth Bach died while incarcerated at the San Diego Central Jail (SDCJ) on 09-28-25.

Board Finding: Approved

Conclusion: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. Bach was arrested by Chula Vista Police on 09-25-23 at approximately 7:30pm for charges related to Criminal Threats and Vandalism. During his initial booking process, Bach lost consciousness and was transported to a local hospital where he received medical treatment for Syncope. Bach was medically cleared at the hospital and booked into San Diego Central Jail (SDCJ) on 09- 26-23 at approximately 2:39am. At the time of his booking, medical staff noted Bach was a type 1 diabetic with an insulin pump. It was further noted that Bach told medical staff he received insulin via the pump up to 8x per day and he advised he would be out of insulin by 8:00am the following day. Bach was classified as a level 2 IP and placed in the X module at 8:07am. While in the X module, medical staff failed to provide his insulin dose at 10:30am. Bach was placed into Module 4A cell #17 on 09-27-23 at 2:24pm and medical staff failed to provide his insulin dose at 3:00pm. On 09-27-23, at approximately 4:05pm, Deputy 4 opened the food flap of Bach's cell in preparation for meal service. Deputy 4 spoke with Bach regarding his insulin pump. See allegation #3 regarding Deputy 4's interaction with Bach. When Bach expressed a need for insulin and medical attention, his cellmates told him to use the intercom button to get assistance with his insulin and described Bach as repeatedly pressing the intercom button. See allegation #4 regarding Deputy 3's assignment as the tower deputy. On 09-27-23, between 4:14pm and 8:50pm, normal safety checks were conducted within the module and Bach took a shower. On 09-27-23, at approximately 9:01pm, Deputy 1 assisted medical staff with medication distribution. The IPs in module 4A were out in the dayroom, requiring medications to be administered via the food flap leading into the module. This necessitated that both Deputy 1 and medical staff stand outside the

module, rather than visiting each cell individually. Notification to the IPs of medication distribution was made by Deputy 1 yelling through the food flap and the tower deputy making an announcement via the module intercom. Per CCTV, IPs began forming a line including Bach's 2 cellmates, who exited their cell, walked downstairs and stood in line. While medications were being distributed, Bach can be seen standing in the doorway of cell #17 but he did not leave the cell. Toward the conclusion of medication distribution, medical staff told Deputy 1 there were still people needing medication and asked him, "Can you call out for last call for medication?" which Deputy 1 did. Bach never showed up for his medication and medical staff never directly observed or interacted with Bach during this incident. At the conclusion of medication distribution, medical staff listed Bach as a refusal and noted Deputy 1's ID# as verification of the -5- refusal. SDSO MSD.R.5 stated, "Refusals for Medications: A. Patient shall sign a refusal form with the specific medication(s) being refused. B. If the patient refuses to sign the refusal form, the nurse (if available) and deputy shall sign the form. C. All refusals shall have the reason documented on the form and scanned in the medical record (when a paper form utilized J223). D. Patient should verbalize understanding of the above advice and the refusal form should be checked by the nurse. E. If the medicine is indicated for a serious medical/psych condition, refer patient to MD/RNP or psychiatrist/PRNP immediately or as soon as possible" and "In all instances of refusal, physicians and nurses shall document health education provided and patient's understanding of the counseling. IX. Document all encounters in the health record." On 09-28-23, at approximately 1:08am, Deputy 2 escorted medical staff into module 4A for the purpose of administering a blood sugar check on Bach. Deputy 2 walked upstairs to Bach's cell while medical staff remained downstairs. Deputy 2 indicated medical staff requested he go upstairs to ask if Bach wanted to take his medication. During his interview, Deputy 2 described, "Sometimes the nurses, they don't want to go upstairs so they ask some of the housing deputies, hey can you just go upstairs and ask for us instead of them physically coming upstairs." Deputy 2 could not recall if Bach was supposed to get a blood sugar check or medication or both stating, "In all the grand scheme it's just medication pass." Deputy 2 observed Bach laying on the floor naked and recalled asking Bach, "Hey, do you want to take it or not?" Deputy 2 described Bach as "laying down and he was gesturing like a shoo away motion with his hand" which Deputy 2 took as a refusal. Deputy 2 further described Bach as looking, "irritated, like he didn't want to be bothered." During this interaction. Deputy 2 described Bach's cellmates as sleeping in their bunks. Even though he did not go upstairs with the deputy, medical staff said he could hear Deputy 2 ask three times if Bach wanted his blood sugar checked. Medical staff could hear an IP

inside the cell respond "no" and when asked again, the IP answer "no" in a louder voice. Medical staff asked if Bach was refusing and the deputy confirmed he refused. When asked if medical staff was supposed to personally go to the cell instead of sending a deputy, medical staff replied, "Now, I should probably go up and check." When asked what the policy required, medical staff replied, "That's probably the policy is the nurse probably has to look at him" and clarified that normal procedure would be the nurse accompanying the deputy. Medical staff said it is common for IPs to refuse insulin at night. Medical staff never directly observed or interacted with Bach during this incident. SDSO MSD.R.5 stated, "Refusals for Medications: A. Patient shall sign a refusal form with the specific medication(s) being refused. B. If the patient refuses to sign the refusal form, the nurse (if available) and deputy shall sign the form. C. All refusals shall have the reason documented on the form and scanned in the medical record (when a paper form utilized J223). D. Patient should verbalize understanding of the above advice and the refusal form should be checked by the nurse. E. If the medicine is indicated for a serious medical/psych condition, refer patient to MD/RNP or psychiatrist/PRNP immediately or as soon as possible" and "In all instances of refusal, physicians and nurses shall document health education provided and patient's understanding of the counseling. IX. Document all encounters in the health record." On 09-28-23, at approximately 2:24am, Deputy 2 assisted medical staff with medication distribution within the module. Deputy 2 and medical staff went to Bach's cell and recorded their interaction as a refusal of medication. On 09-28-23, at approximately 2:37am, Deputy 2 and Deputy 5 conducted a safety check of the module. See allegation #7 regarding Deputy 2 and Deputy 5's safety check. On 09-28-23, at approximately 3:35am, Deputy 1 and Deputy 2 conducted a safety check of the module. While checking Bach's cell, Deputy 1 observed Bach laying naked on the floor but could not tell if he was breathing. Deputy 1 and Deputy 2 entered the cell and found Bach unconscious and not breathing. Deputies initiated CPR and requested medical assistance with a nurse arriving at the cell at approximately 3:40am. CPR continued until Fire personnel arrived and took over. CPR and medical aid were administered until approximately 4:09am when it was stopped and Bach was pronounced deceased. Bach's diagnosis of type 1 diabetes and use of an insulin pump was noted at intake. Bach was prescribed 10 units of Novolin (insulin) 3 times per day at mealtimes (3:30am, 10:30am, 3:00pm). Two separate orders for blood sugar checks were made. Statcare ordered them twice a day and SDCJ medical staff ordered them 4 times per day. Bach's blood sugar was checked seven times between 3:05am on 09-26-23 and 1:53am on 09-27-23. Insulin was administered two times, at 4:43pm on 09-26-23 and 1:53am on 09-27-23. While housed in the X module, medical staff failed to provide Bach

insulin on 09-27-23 at 10:30am. Bach was also scheduled for insulin at 3:00pm but was transitioned into module 4A at approximately 2:24pm and was not provided insulin at 3:00pm. There are no records of Bach receiving any blood sugar checks or insulin during the approximate 12 hours he was housed in module 4A. There are three records of refusals during Bach's time in module 4A for both blood sugar checks and insulin. At the time of his death, Bach had missed three consecutive administrations of insulin. Per the Medical Examiner's report, Bach's death was the result of diabetic complications. "Based on the autopsy findings and the circumstances surrounding the death, as currently understood, the cause of death is diabetic ketoacidosis due to type 1 diabetes mellitus with hypertensive and atherosclerotic cardiovascular disease as a contributing condition. The death is due to complications of a natural -6- disease. However considering the inaction (i.e., neglect) characterizing the events leading to inadequate care while incarcerated of Mr. Bach's health conditions and ultimately his death, the manner of death is classified as homicide." Deputy 1 provided a confidential statement during CLERB'S investigation that was taken into consideration. A Department Informational Source provided a confidential statement during CLERB'S investigation that was taken into consideration. Deputy 2 provided a confidential statement during CLERB'S investigation that was taken into consideration. Per CLERB Rules & Regulations 16.1, at the conclusion of a matter before the entire CLERB, CLERB shall deliberate and adopt a final report ("Final Report") with respect to the case or matter under consideration. This report shall include Findings as to the facts relating to any case, as well as an overall conclusion as to any case as specified in Section 16.2.

1. Misconduct/Procedure - Medical staff failed to provide IP Bach with insulin.

Board Finding: Summary Dismissal

Staff Recommended Finding: Summary Dismissal Rationale: See Rationale: Pursuant to CLERB Rules and Regulations, Section 15, Summary Dismissal, CLERB does not have jurisdiction over the subject matter of the allegation.

2. Misconduct/Procedure – Deputy 4 failed to relay Bach's request for medical attention to medical staff.

Board Finding: Not Sustained

Staff Recommended Finding: Not Sustained

Rationale: Per CCTV, at approximately 4:05pm, Deputy 4, in preparation for meal distribution, arrived at cell #17 and opened the food flap. Deputy 4 appeared to be in conversation with an IP

within the cell, ultimately leaning into the open food flap and looking into the cell. At approximately 4:06pm Deputy 4 walked away and continued to open the remaining cell food flaps. Deputy 4 reported to detectives he could not recall the specifics of the interaction other than Bach showing him his insulin pump and telling Deputy 4 he takes insulin. Deputy 4 recalled contacting medical staff and confirming that Bach takes insulin. Deputy 4 indicated it was unusual for an IP to have an insulin pump stating, "So when he showed that to me, I was like that's kinda weird because we don't have those in here." In response to a question if Deputy 4 told medical that Bach needed or was out of insulin, Deputy 4 replied, "No, if he was out of it I would have taken him, like if there was medical distress or if I felt he needed medical attention then, I would have taken him down." Deputy 4 noted that Bach appeared to be healthy, not in distress and said he did not hear any beeping from the insulin pump. Per an interview with IP Redacted, Bach's cellmate, IP Redacted stated Bach told a deputy he was out of insulin and needed more. IP Redacted was not able to identify the deputy who Bach allegedly reported this to. SDSO DSB policy M.13 outlined who is responsible for the medical care of IPs as, "Detention facility qualified health providers (QHP) (e.g., physicians, nurse practitioners) are primarily responsible for the medical treatment, planning, and referral to any necessary outside medical service when deemed necessary. QHPs are also responsible for providing emergency medical care and will determine additional treatment or referral to an emergency department, if needed. Within their respective scopes of practice detention facility registered nurses and licensed vocational nurses are responsible for responding and rendering emergency care and referral, logistical support of all patient/doctor activity, screening interviews, administration of medications, implementation of all physician's orders and treatment, and special programs." The evidence showed Deputy 4 had a conversation with Bach regarding his use of an insulin pump. What is unclear is the exact nature of the conversation. SDSO DSB policy M.5 outlined, "All facility staff shall be responsible for taking appropriate action in recognizing, reporting or responding to an incarcerated person's emergency medical needs. In any situation requiring medical response, emergency medical care shall be provided with efficiency and speed without compromising security. The statements from Deputy 4 and IP Redacted confirm a conversation took place regarding the insulin pump but conflict about whether a "request for insulin" was made by Bach. It was evident that that Deputy 4 did not view Bach or his circumstances as urgent or in need of emergency medical care. A Department Informational Source also provided a confidential statement during CLERB'S investigation that was taken into consideration. By a preponderance

of the evidence, CLERB determines the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

3. Misconduct/Procedure – Deputy 3 failed to respond to intercom requests.

Board Finding: Not Sustained

Staff Recommended Finding: Not Sustained

Rationale: Bach's cellmate, IP Redacted, described Bach as repeatedly pressing the intercom button within the cell to request assistance with his insulin. Another IP also described Bach as pressing the intercom button, but said Bach only received one response consisting of, "sorry." Deputy 3 was the only deputy working in the 4th floor tower. One of his responsibilities was to communicate with IP's through the intercom system. Per the evidence reviewed, Deputy 3 said he did not receive any intercom contact from cell #17. Deputy 3 explained the intercoms were working, saying, "throughout the whole night I had other IP's press the button and I talked to them." The intercom system used by SDCJ, at that time, did not have the ability to record activations of the system, so there is no activation log to review. During SDSO's investigation, detectives tested the intercom in cell #17 to determine if it was functional. Detectives pushed the button within the cell and heard a "faint response through the intercom speakers, but the volume was too low to understand what was being said." Detectives in the control tower confirmed it activated with flashing lights and beeping on the monitor but said they could only hear "what sounded like wind." During a later test of the system in the tower, responses can be heard from both cell #17 and cell #16 though they were faint. SDSO DSB Policy I.2, Intercom Systems outlined, "Intercoms are generally located in areas accessible by incarcerated persons (e.g., dayrooms, cells, classrooms, etc.). Each facility shall maintain an inmate intercom system for the purpose of providing a means of communication between sworn staff and incarcerated persons. Intercom systems should be primarily used as a means of relaying and or summoning emergency assistance. Intercoms shall not be routinely muted or silenced." Deputy 3 also provided a confidential statement during CLERB'S investigation that was taken into consideration. By a preponderance of the evidence, CLERB determines the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

4. Misconduct/Procedure – Medical staff failed to follow a refusal policy during medication distribution.

Board Finding: Summary Dismissal

Staff Recommended Finding: Summary Dismissal

Rationale: See Rationale 1. Pursuant to CLERB Rules and Regulations, Section 15, Summary Dismissal, CLERB does not have jurisdiction over the subject matter of the allegation.

5. Misconduct/Procedure – Medical staff failed to follow a refusal policy during medication distribution.

Board Finding: Summary Dismissal

Staff Recommended Finding: Summary Dismissal

Rationale: See Rationale 1. Pursuant to CLERB Rules and Regulations, Section 15, Summary Dismissal, CLERB does not have jurisdiction over the subject matter of the complaint.

6. Misconduct/Procedure – Deputies 1 and 5 failed to recognize IP Bach's need for emergency medical attention during a safety check.

Board Finding: Not Sustained

Staff Recommended Finding: Not Sustained

Rationale: At approximately 2:37am, Deputy 1 conducted a safety check of the module and Deputy 5 conducted a supervisor inspection check. During his check, Deputy 1 looked into cell #17, moved onto the next cell briefly before returning to cell #17 where he observed Bach lying on the floor naked. Per an interview conducted by SDSO detectives, Deputy 1 stated, "It's not uncommon to see fully naked people in the jails" but it was "just kind of odd, that's why I stopped and paused a little bit and went back just to make sure everything's ok or somethings going on." The evidence showed, while Deputy 1 was looking into Bach's cell, Deputy 5 arrived and also noted Bach was laying on the floor naked. Deputy 5 also indicated it is common to see IPs sleeping on the floor and did not consider it unusual for Bach to be naked stating, "I was told the cells are hot in there so that might explain why he didn't have any clothes on." Both Deputy 1 and Deputy 5 observed the "rise and fall" of Bach's chest and believed Bach was sleeping. Neither Deputy 1 nor Deputy 5 observed any obvious symptoms of distress. Despite seeing no signs of obvious distress, Deputy 5 and Deputy 1 spent approximately 1:32 looking into Bach's cell before determining they could see the rise and fall of his chest. The rest of their cell checks each lasted approximately 5 seconds or less. SDSO DSB Policy I.64 stated, "Sworn staff will conduct safety checks of incarcerated persons, housing areas, holding areas and vacant cells through direct visual observation (i.e., direct personal view of the incarcerated person/area without the aid of audio/video equipment). Safety checks of incarcerated persons consist of looking at the

incarcerated persons for any obvious signs of medical distress, -8- trauma or criminal activity." SDSO DSB Policy I.23 stated, "At least three times per pay period, the shift watch commander is responsible for conducting an inspection of housing and operational areas. The watch commander shall perform the inspection twice on the (5) five, with at least (1) one day in between checks, and once on any day of the two on. The inspection shall be conducted in the form of a safety check paying attention to health and hygiene problems, maintenance issues, security issues and the overall condition of the facility to include all staff work areas, common areas used for access in, out and around their facility i.e. (walkways/stairs/elevators)." Deputy 5 and Deputy 1 provided confidential statements during CLERB'S investigation that were taken into consideration. By a preponderance of the evidence, CLERB determines the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

POLICY RECOMMENDATIONS:

It is recommended that the San Diego Sheriff's Office (SDSO) clarify and align Detentions policy with MSD R.5 to ensure compliance and prevent deputies from being the sole decision-maker for medication refusal.

It is recommended that the San Diego Sheriff's Office (SDSO) institute the use of technology to monitor the health and safety of people in custody at San Diego detention facilities.

It is recommended that the San Diego Sheriff's Office (SDSO) designate incarcerated persons with Type-1 diabetes with a medical alert status that is clearly communicated to relevant sworn staff. Further, it is recommended that the SDSO implement refresher training regarding the identification of signs and symptoms of diabetic emergencies.

APPENDIX C: POLICY RECOMMENDATIONS RECEIVED IN 2025

This section compiles policy recommendations responses provided by the San Diego Sheriff's Department (SDSO) and Probation Department. In 2025, all recommendations received were from the San Diego Sheriff's Office (SDSO). Each recommendation is presented in a structured format for clarity:

Case Number: The unique identifier assigned to the policy recommendation by CLERB.

Synopsis of Policy Recommendation: A summary of the recommendation made by CLERB regarding SDSO policies or procedures.

Date CLERB Received Response: The date SDSO formally responded to the recommendation.

Response: SDSO's official stance on the recommendation (e.g., Accepted, Not Accepted, Partially Accepted, or Other).

Additional Comments: Detailed explanation provided by SDSO to justify or clarify their response, including references to existing policies, operational constraints, or planned actions.

Case 23-086

Synopsis of Policy Recommendation:

Disclose how its records may be disclosed to an attorney, upon request, unless there are privacy and/or public safety exemptions which would prevent doing so.

Date CLERB Received Response: 9-16-25

Response: Not Accepted

Additional Comments:

Only can provide assistance with CPRA requests. SDSO not trained on nuances of civil and criminal law.

Case 23-025

Synopsis of Policy Recommendation:

1. Mandate the logging of shower access when an Incarcerated Person (IP) is in lockdown.

2. Create a policy to ensure IPs have access to CLERB complaint packets.

Date CLERB Received Response: 3-4-25

Response: Partially Accepted

Additional Comments:

In reference to recommendation number one (1), SDSO updated Detention Services Bureau (DSB) Policy and Procedure L.11 'Personal Hygiene' (attached for reference) to require logging of shower access for incarcerated persons in Disciplinary Separation, AKA 'lockdown.' The revisions to policy L.11 are listed below:

III. DISCIPLINARY SEPARATION

A. Any incarcerated person in disciplinary separation will be allowed a shower at least every 48 hours. A JIMS entry will be made in the incarcerated person's history using the 'SHWR' drop-down to indicate when the incarcerated person was given access to the shower. If the incarcerated person chooses not to utilize the shower, an entry will be made in the incarcerated person's history using the 'SHWR' drop-down and enter 'REFUSED SHOWER' in the 'Destination' area.

In reference to recommendation number two (2), SDSO has no plans to create a policy specific to incarcerated persons' access to CLERB complaint forms. To address those concerns though, SDSO Correctional Counseling staff, whose duties include providing education and community resource services to incarcerated persons, have been instructed to provide incarcerated persons with CLERB complaint forms upon request.

Case 22-148

Synopsis of Policy Recommendation:

Amend SDSD P&P Section 6.131, Body Worn Cameras, to require that deputies in plain clothes assignments, including members of task forces, are not required to wear BWC's; however, they will utilize a BWC when working or assigned to a uniformed patrol assignment or when donning an external vest.

Date CLERB Received Response: 3-4-25

Response: Partially Accepted

Additional Comments:

The current policy states, 'BWC's shall be worn by uniformed personnel at all times during on duty hours in a law enforcement capacity, unless directed by a supervisor.' (SDSO P&P Section 6.131). This policy applies to Task Force Officers who don an external vest and are 'in uniform' while making enforcement contacts. The exception would be for Task Force Officers assigned to a federal task force where a separate agreement has been entered into with the Sheriff. Other incidents that might limit the use of a BWC by a deputy would include operations on other

federal task forces (DEA, U.S. Marshal's Office, etc.). The Sheriff continues to work with these partners to balance the value of this technology with the nature, value, and sensitivity of these investigations and federal parameters. The addition of verbiage to Sheriff's Policy 6.131 outlining the use of BWC's complying with task force operation agreements is reasonable and will be added.

Case 22-043

Synopsis of Policy Recommendation:

Define facility incident video retention to include all critical incidents as defined by SDSD P&P 4.23 Department Committees and Review Boards: Critical Review Board. CLERB also recommends facility incident videos are retained for twelve hours prior to and after incident occurrence.

Date CLERB Received Response: 3-4-25

Response: Not Accepted

Additional Comments:

In response to this request, the Sheriff's Homicide Unit was consulted. The Homicide Unit advised their current practice is to have twenty-four (24) hours of detention facility surveillance video retained for the time period taking place prior to an in-custody death incident. The Homicide Unit may retain post-incident surveillance footage on a case-by-case basis when investigators determine such footage has evidentiary value related to their investigation. The Homicide Unit does not retain twelve (12) hours of detention facility surveillance video after an incident concludes, as that footage generally has no evidentiary value related to their investigation.

Case 21-130

Synopsis of Policy Recommendation:

1. Enact a procedure that allows for the safe placement of all IPs who are released from custody, regardless of the circumstances of their release. In addition to a policy that governs all release, it is recommended that IPs shall not be allowed to return to housing if released from or while at court.

2. Provide Jail Population Management Unit deputies the ability to review and consider juvenile records and sealed records in cases they deem necessary.

Date CLERB Received Response: 3-4-25

Response: Not Accepted

Additional Comments:

In regard to recommendation number one (1), the policies and procedures governing the various release processes for incarcerated persons are found in San Diego County Sheriff's Office (SDSO) Detention Services Bureau (DSB) Policy and Procedure Q.70 (Release of Incarcerated Persons at Court), Q.73 (Arraignment and Release Under PC 825), Q.74 (Probable Cause Rejections), Q.75 (Release of Served Time Incarcerated Persons) and Q.77 (Permissive Release of Pre-Arraignment Misdemeanor Incarcerated Persons). Each of these types of releases requires different procedural steps and resources that cannot be generalized into one policy that governs all types of releases. Reference recommendation number two (2), JPMU faces challenges viewing the juvenile records of adult incarcerated persons booked into SDSO detention facilities. While juvenile authorities such as the Probation Department and the Deputy District Attorneys assigned to the Juvenile Division have access to data about justice-involved youth, much of that information is protected under the law, can only be released by order of the Juvenile Court, and is inaccessible to JPMU.

Case 23-069

Synopsis of Policy Recommendation:

It is recommended that the San Diego Sheriff's Department (SDSD) update and align P.3 Incarcerated Person (IP) Mail Policy, B.5 Money Orders and Checks, and facility-specific Green Sheets, with respect to IP legal mail, to be all inclusive for the receipt, processing and distribution of IP legal mail.

Date CLERB Received Response: 9-17-25

Response: Accepted

Additional Comments:

The Sheriff's Office updated DSB P&P P.3 'incarcerated Person Mail' on January 21, 2025, to provide consistent directions in the handling of legal mail to SDSO DSB personnel office-wide.

Case N/A

Synopsis of Policy Recommendation:

It is recommended that the Sheriff's Department Internal Affairs (IA) department consider a toll-free number or accept collect calls through whatever method is necessary to ensure everyone, including incarcerated persons are able to file a complaint.
Date CLERB Received Response: 8-5-25
Response: Not Accepted
Additional Comments:
As a way to ensure the accessibility to IA, the incarcerated population does not have to pay for phone calls. There is a direct phone number to IA posted in each housing module for them to file complaints. There is a recorded system where the caller can leave a message at any time, and the complaint will be entered in our tracking system and followed up on. In addition, collect calls are authorized and can be made into Sheriffs Headquarters, where IA is located. The phone system is not setup to block collect calls.

Case 23-079

Synopsis of Policy Recommendation:
It is recommended the San Diego Sheriff's Department (SDSD) develop policy and procedure to retain routine jail video for at least one year. CLERB strongly recommends for the retention beyond one year for CLERB to investigate complaints that may come in towards the end of CLERB's filing time periods.
Date CLERB Received Response: 10-15-25
Response: Other (see additional comments)
Additional Comments:
Received via email. The original investigator only cited SDSO P&P B.37 which referred to record retention and destruction. However, F.1 'Records Maintained' showed a retention period of 'Facility Incident Videos' as two years. That policy was in place when the PR was sent to SDSO.

Case 22-056

Synopsis of Policy Recommendation:
It is recommended the San Diego Sheriff's Department implement a policy which ensures temporary holding cells are searched for any contraband prior to an incarcerated person (IP) being placed there.
Date CLERB Received Response: 10-14-25
Response: Not Accepted

Additional Comments:
On average, the San Diego County Sheriffs Office (SOSO) processes between 150 and 400 new bookings a day of incarcerated persons amongst three booking detention facilities. Those booking facilities include the San Diego Central Jail (SDCJ), the Las Colinas Detention and Reentry Facility (LCD RF), and the Vista Detention Facility (VDF). The majority of holding cells in the booking areas of these facilities are often occupied at all times of the day or night. It would be impractical to empty and search holding cells prior to placing each incarcerated person into a holding cell as multiple incarcerated persons are typically housed in the holding cells and moved into and out of these cells throughout the booking process until they are either released or moved to another floor for long-term housing.

Case 22-113

Synopsis of Policy Recommendation:
It is recommended that the Sheriff's Department employ personnel with a special expertise and background in both image reading and medical to conduct and read body scans at SDSD facilities.
Date CLERB Received Response: 9-17-25
Response: Not Accepted
Additional Comments:
These body scan machines are designed to be used by personnel who do not require a 'special expertise and background in both image reading and medical.'