County of San Diego

CITIZENS' LAW ENFORCEMENT REVIEW BOARD

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REGULAR MEETING AGENDA
TUESDAY, JUNE 13, 2017, 4:00 P.M.
San Diego County Administration Center
1600 Pacific Highway, Room 302/303, San Diego, 92101

(Free parking is available in the underground parking garage, on the south side of Ash Street, in the 3-hour public parking spaces.)

Pursuant to Government Code Section 54954.2 the Citizens' Law Enforcement Review Board will conduct a meeting at the above time and place for the purpose of transacting or discussing business as identified on this agenda. Complainants, subject officers, representatives or any member of the public wishing to address the Board on any of today's agenda items should submit a "Request to Speak" form prior to the commencement of the meeting.

DISABLED ACCESS TO MEETING

A request for a disability-related modification or accommodation, including auxiliary aids or services, may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting. Any such request must be made to CLERB at (619) 238-6776 at least 24 hours before the meeting.

WRITINGS DISTRIBUTED TO THE BOARD

Pursuant to Government Code 54957.5, written materials distributed to CLERB in connection with this agenda less than 72 hours before the meeting will be available to the public at the CLERB office located at 555 W Beech Street, Ste. 505, San Diego, CA.

1. ROLL CALL

2. MINUTES APPROVAL

a) Minutes of the May 2017 Regular Meeting *(Attachment A)*

3. PRESENTATION / TRAINING

a) N/A

4. EXECUTIVE OFFICER'S REPORT

a) Workload Report - Open Complaints/Investigations Report *(Attachment B)*

5. BOARD CHAIR REPORT

-continued on next page-

6. NEW BUSINESS

a) Establish CLERB's regular meeting schedule

7. UNFINISHED BUSINESS

a) CLERB Rules and Regulations Subcommittee Update

b) 2015 Annual Report Draft

8. BOARD MEMBER COMMENTS

9. PUBLIC COMMENTS

a) This is an opportunity for members of the public to address the Board on any subject matter that is within the Board's jurisdiction. Each speaker should complete and submit a "Request to Speak" form to the Administrative Secretary. Each speaker will be limited to five minutes.

10. SHERIFF / PROBATION LIAISON QUERY

11. CLOSED SESSION

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

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

CASES FOR SUMMARY HEARING (5)

ALLEGATIONS, RECOMMENDED FINDINGS & RATIONALE

14-006

1. Death Investigation/Officer-Involved Shooting – Deputies 2 and 3 shot and killed Michael Napier while attempting to arrest him.

   Recommended Finding: Action Justified
   Rationale: There was no complaint of wrongdoing in this death investigation; a review was conducted in

accordance with CLERB Rules & Regulations, 4.6 Citizen Complaint Not Required: Jurisdiction with Respect to Actions involving Death. On the date of the incident, Napier was wanted on an outstanding felony warrant for 11377 (a) H&S - Possession of a Controlled Substance; he was also the suspect in a recent theft and a burglary in and around the complex where he resided. The Gang Enforcement Team (G.E.T.) deputies had intelligence that Napier was a dangerous suspect who was known to carry weapons and had a history of violent confrontations with law enforcement officers, including a prior incident in which he shot at officers during a traffic stop. Intel further indicated that Napier was living in his father's detached garage and according to a recent social media post, "would possibly be leaving town soon." The team decided that they would surveil Napier's complex and if found, they would serve the felony warrant and take Napier into custody. Deputies 2 - 5 contacted Napier at the garage and instructed him to show them his hands. Three of the four deputies who actually saw and heard Napier's initial response when contacted, provided differing accounts of Napier's responses prior to Deputies 2 and 3 discharging their weapons. The research shows that during critical incidents, the substantial majority of officers experience specific perceptual distortions, causing their recollection of the events of the shooting to be imperfect. Deputies 2 and 3's account of this critical incident, while different in some respects, culminated with reports of Napier reaching toward or in his pocket or waistband after being ordered to keep his hands up. Fearing for their safety, Deputies 2 and 3 reacted to this threat by discharging several rounds from their duty weapons, fatally injuring the decedent. The discharge of their firearms was legal, justified and proper under the Sheriff Department's Policies & Procedures, and state law.

15-043

1. Death Investigation/ Positional Restraint – Deputies 4 & 6 struck, batoned, and tasered Lucky Phounsy until Deputies 1-3, 5, and 7-11 assisted with control and placement into maximum restraints. During transport, the decedent stopped breathing.

   Recommended Finding: Action Justified
   Rationale: There was no complaint of wrongdoing in this death investigation. Deputies were called to the scene by Phounsy who experienced paranoid delusions from illicit drug use. Phounsy initially allowed deputies to search him for contraband, but then as he was being cuffed for officer safety, the complainant used an unsecured handcuff to assault the deputies. Deputies 4 and 6 responded with authorized force options that had little to no effect on the complainant. A vicious fight lasting approximately five minutes ensued, until a family member and then cover deputies assisted. The complainant continued to resist even after placed into maximum restraint and after paramedics administered sedatives. The decedent was so violent in the ambulance, paramedics were unable to obtain vital signs or render aid, until he became unresponsive. An autopsy declared the cause of death was "anoxic encephalopathy, due to cardiopulmonary arrest with resuscitation following physical altercation and restraint, due to stimulant drug-related psychotic state" with "cardiac arteriolosclerosis" listed as a contributing condition, and the manner of death as "accident." The Medical Examiner reported that it did not appear that injuries from the altercation with police or the restraint itself were the cause of the decedent's cardiac arrest and subsequent death, as he was in a safe position and being administered oxygen when he experienced his sudden death arrest several minutes after the altercation. The actions of the deputies in their attempt to gain control of an assaultive prisoner were not excessive, but necessary. The evidence showed the alleged acts occurred and were lawful, justified and proper.

16-027

1. Death Investigation/Inmate Suicide –Richard Boulanger was found in his cell hanged by the neck with a sheet attached to the bed frame.

   Recommended Finding: Not Sustained
   Rationale: There was no complaint of wrongdoing in this death investigation; a review was conducted in accordance with CLERB Rules & Regulations, 4.6 Citizen Complaint Not Required: Jurisdiction with Respect to Actions involving Death. On February 12, 2016, Boulanger's cellmate awoke to find him hanging from the bunk

bed with what appeared to be a rope fabricated from a sheet around his neck. The cellmate reported that he pressed the intercom button 4-5 times to call for help. When no one answered the intercom, he stated that he started banging on the door and yelling for help. Per the cellmate's account, it took approximately 10 to 20 minutes before deputies arrived. The cellmate was observed on surveillance video standing in front of his cell door for approximately 5 minutes before contacted by deputies during their opening shift count. Upon being alerted, detentions staff responded quickly to secure the unit and allow medical staff to begin resuscitative efforts. Boulanger was subsequently transported to UCSD Medical Center, but his condition continued to decline as he developed multisystem organ failure. On February 14, 2016, he became pulseless and apneic and his death was pronounced. The Medical Examiner attributed the cause of death to acute diffuse anoxic/ischemic encephalopathy, due to resuscitated cardiac arrest, due to ligature hanging, and the manner of death is classified as suicide. Detentions staff classified and housed the decedent according to Department policies and procedures; however, there is insufficient evidence to prove or disprove to what extent identified policy violations impacted Boulanger's suicide death.

2. Misconduct/Truthfulness – Deputy 2 was untruthful when he reported conducting a well-being check on the module.

   Recommended Finding: Sustained
   Rationale: Department Policy and Procedure 2.46, Truthfulness, requires all personnel, "…to answer questions, whether orally or in writing, truthfully and to the fullest extent of their knowledge." Deputy 2 reported during an interview and in a written response to CLERB that he had conducted a Soft Count – which is an inmate count that "verifies each inmate's well-being through verbal or physical acknowledgement from the inmate" – between the hours of 5:15 and 5:35pm. Video surveillance of that time frame disproved the actions he described and Deputy 2 declined an interview to provide an explanation for his statement and actions. The evidence supported the allegation, and the conduct was not justified.

3. Misconduct/Procedure – Deputy 2 failed to conduct an end of shift Soft Count according to policy.

   Recommended Finding: Sustained
   Rationale: Sheriff's Detentions Policy I.43, Inmate Count Procedure, establishes a uniform procedure for physically counting and verifying the well-being of all inmates within the facility. A Soft Count is one of the three types of inmate counts and requires that detentions staff verifies each inmate's well-being through verbal or physical acknowledgement from the inmate. San Diego Central Jail's Green Sheet policy further requires that a Soft Count is conducted at the beginning and end of every shift, and that a printed Operations Report (Count Sheet) is utilized while conducting these Soft Counts. Deputy 2 reported conducting a security check, also known as a Head Count, during his end of shift count, and did not conduct a Soft Count as required by policy. Moreover, Deputy 2 did not utilize a printed Operations Report during this count, which is also required by policy. Deputy 2 declined an interview to provide an explanation for his actions. Surveillance video of Deputy 2's end of shift count verifies that he did not conduct a Soft Count as required, and this act was not justified.

4. Misconduct/Procedure - Deputy 1 failed to respond to an inmate's attempt to contact him through the jail's intercom system.

   Recommended Finding: Sustained
   Rationale: Sheriff's Detentions Policy I.1, Emergency Alarms Systems, provides a means for detention facility staff and inmates to summon emergency assistance. Alarm buttons located in inmate cells are required to be connected to a central control area to ensure a constant monitoring of the alarms with appropriate, timely assistance dispatched to the scene of any alarm. The Control deputy is tasked to monitor this alarm system and is required to dispatch assistance when the alarm is activated. Boulanger's cellmate reported that upon discovering the decedent's body hanging from the bunk bed with what appeared to be a rope fabricated from a sheet around his neck, he pressed the intercom button 4-10 times to call for help, but no one answered. Per the cellmate's account, it took approximately 10 to 20 minutes before deputies arrived. The cellmate was observed on surveillance video standing in front of his cell door for approximately 5 minutes before contacted by deputies during their opening shift count. Deputy 1 was the assigned Control deputy at the time of this incident. He reported that sometime prior to his shift; the audio alert function of the inmate intercom system had been muted,

with the volume turned all the way down. This prevented him from hearing the cellmate's attempted contact. Visual alerts from the decedent's cell, however, had been triggered and were observable on the intercom monitor; but according to Deputy 1, he customarily does not check the monitor until approximately 30 minutes after arriving in the control room, and after performing his pre-check duties. On this particular day, he had not observed the monitor prior to being contacted by housing deputies requesting that he open the decedent's cell door. When opening the cell door, Deputy 1 then observed the flashing red light on the monitor that corresponded to the decedent's cell. Deputy 1 declined an interview to provide an explanation for his actions. Policy requires that the Control deputy monitors the emergency alarm system and immediately dispatch assistance when an alarm is activated. The decedent's cellmate activated the alarm, but Deputy 1 failed to respond and this act was not justified.

POLICY RECOMMENDATION:

1. It is recommended that the San Diego Sheriff's Department ensure compliance with Sheriff's Policy I.1, Emergency Alarms Systems that explicitly directs the Control Deputy to dispatch assistance when an inmate emergency alarm is activated. To address an unspecified element of this policy, it is recommended that an addendum to the existing policy be drafted that directs the Control Deputy to immediately check the inmate intercom monitor for visual alerts at the beginning of each shift, and to ensure that the audio alerts on the monitor have not been disabled.

2. It is further recommended that policy be drafted that strictly prohibits detentions staff from muting or otherwise disabling the audio component of the inmate intercom monitor, or lowering its volume to an inaudible level.

16-068

1. Misconduct/Procedure – Deputy 1 allegedly failed to conduct a thorough investigation into the complainant's report of elder abuse.

   Recommended Finding: Summary Dismissal
   Rationale: The complainant made a number of allegations against Deputy 1 without providing any evidence in support of her claims. The complainant failed to establish a prima facie showing of misconduct. Such complaints may be referred to the Review Board for Summary Dismissal, pursuant to CLERB Rules & Regulations: Section 9: Investigation of Complaints; Subsection 9.2: Screening of Complaints.

2. Criminal Conduct – Deputy 1 allegedly conspired with other parties to commit fraud and other illegal activities against the complainant's husband.

   Recommended Finding: Summary Dismissal
   Rationale: See Rationale

16-079

1. Excessive Force - Deputies 1, 2, 4-8, allegedly beat the complainant's entire body with objects in their hands while he was being booked into jail.

   Recommended Finding: Action Justified
   Rationale: The complainant reported that after he was arrested and beaten by California Highway Patrol (CHP) officers, he was assaulted again by deputies while being booked into jail. The complainant was arrested for evading and resisting arrest, and also for being under the influence of drugs. After treatment at a hospital, the complainant was cleared to be booked into jail. While there, the complainant lunged through a closing cell door and a use of force occurred involving a taser, body strikes and control holds. The complainant did not comply with deputies' commands and he displayed active resistance and assaultive behavior, which was corroborated

by surveillance video. The evidence showed that the deputies' actions were necessary to regain control of the noncompliant complainant, and were lawful, justified and proper.

2. Misconduct/Procedure – Deputy 3 allegedly refused to provide instruction(s) and/or allow the complainant a telephone call.

   Recommended Finding: Action Justified
   Rationale: The complainant reported that deputies refused to tell him anything and would not allow him to telephone his father. Deputy 3 reported that the while the complainant was in the bail out cell, he reported that he could not use the telephones. Directions were reportedly provided to him multiple times and he was moved to different cells in order to correct the problem. It was subsequently confirmed that the phone system was operational, and the complainant incapable of performing this simple task, because he was impaired. Based upon the complainant's charges of being under the influence of drugs, he was found not to be credible in his recall of these events. The evidence showed that there was no malfunction of the telephone system at the jail and that the complainant was not denied use of the telephones; he was just incapable of placing a call due to his altered state.

End of Report