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PAUL R. PARKER III

**County of San Diego**  
**CITIZENS' LAW ENFORCEMENT REVIEW BOARD**

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**MEETING AGENDA**

**Tuesday, January 11, 2022, 5:30 p.m.**

**Remote Meeting Zoom Platform**

<https://zoom.us/j/94512256975?pwd=blkzMWczNk9xQldiSU6NnA3aHhYQT09>

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

**DISABLED ACCESS TO MEETING**

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

**WRITINGS DISTRIBUTED TO THE BOARD**

Pursuant to Government Code Section 54957.5, written materials distributed to CLERB in connection with this agenda less than 72 hours before the meeting will be available to the public at the CLERB office located at 555 W Beech Street, Ste. 220, San Diego, CA.

**1. ROLL CALL**

**2. PUBLIC COMMENTS**

This is an opportunity for members of the public to address the Board on any subject matter that is within the Board's jurisdiction but not an item on today's open session agenda. Each speaker shall complete and submit an online "[Request to Speak](#)" form. Each speaker will be limited to three minutes. This meeting will be held remotely via the Zoom Platform. Click the below link to access the meeting using the **Google Chrome web browser**: <https://zoom.us/j/94512256975?pwd=blkzMWczNk9xQldiSU6NnA3aHhYQT09>. Please contact CLERB at [clerb@sdcounty.ca.gov](mailto:clerb@sdcounty.ca.gov) or 619-238-6776 if you have questions.

**3. MINUTES APPROVAL (Attachment A)**

**4. PRESENTATION/TRAINING**

- a) Summary of Detention Services Bureau (DSB) In-Custody COVID-19 Vaccination and Testing Process by San Diego Sheriff's Department Sergeants Kristin Brayman and Daniel Dennis
- b) County's Role in COVID-19 Vaccination of San Diego County Detention Facility Inmates by CLERB Executive Officer Paul Parker

## **5. EXECUTIVE OFFICER'S REPORT**

- a) Overview of Activities of CLERB Executive Officer and Staff
- b) Workload Report – Open Complaints/Investigations Report (*Attachment B*)
- c) Case Progress and Status Report (*Attachment C*)
- d) Executive Officer Correspondence to Full CLERB (*Attachment D*)
- e) Policy Recommendation Pending Responses
  - i. 20-063 / Morton (Death) – SDSD
  - ii. 20-097 / Huie – SDSD
  - iii. 20-113 / Alvarez (Death) – SDSD
  - iv. 21-060 / Meadows – SDSD
  - v. CLERB Staff Response to Death Scenes – SDSD
  - vi. CLERB Staff Response to Death Scenes – Probation
- f) Request for Report Back from SDSD
  - i. Address Concerns Identified in Center for Policing Equity Report
- g) Sustained Finding Pending Responses
  - i. 20-113 / Alvarez (Death) – SDSD
  - ii. 21-087 / Grino-Watson – SDSD

## **6. BOARD CHAIR'S REPORT**

## **7. NEW BUSINESS**

- a) Continuance of Teleconferencing Meeting Option Pursuant to Government Code Section 54953(e)
- b) Overview of “Notice of Adverse Action” Service Process
- c) Overview of 2021 NACOLE Conference

## **8. UNFINISHED BUSINESS**

- a) Update: Authority for the Executive Officer to Work with County Staff to Pursue Legislation and/or to Add a Policy to the County Legislative Program in Support of Increased Transparency in Civilian Oversight of Peace Officers and Custodial Officers
- b) Update: Authority for the Executive Officer to Work with County Staff to Request that the County Board of Supervisors Expand CLERB's Jurisdiction to Include Personnel Involved in Providing Medical Care in County Detention Facilities
- c) Update: Racial Disparity and Racial Profiling Subcommittee
- d) Update: In-Custody Death Data Review Subcommittee

**9. BOARD MEMBER COMMENTS**

**10. SHERIFF/PROBATION LIAISON QUERY**

**11. CLOSED SESSION**

a) AUDIT BY CALIFORNIA STATE AUDITOR’S OFFICE (Gov. Code Section 54956.75(a))

b) PUBLIC EMPLOYEE DISCIPLINE/DISMISSAL/RELEASE

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

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

**NOTICE: THE CITIZENS LAW ENFORCEMENT REVIEW BOARD (CLERB) MAY TAKE ANY ACTION WITH RESPECT TO THE ITEMS INCLUDED ON THIS AGENDA. RECOMMENDATIONS MADE BY STAFF DO NOT LIMIT ACTIONS THAT THE CLERB MAY TAKE. MEMBERS OF THE PUBLIC SHOULD NOT RELY UPON THE RECOMMENDATIONS IN THE AGENDA AS DETERMINATIVE OF THE ACTION THE CLERB MAY TAKE ON A PARTICULAR MATTER.**

**CASES FOR SUMMARY HEARING (6)**

**20-104**

1. Death Investigation/In-Custody Medical – Inmate Anthony Chon collapsed in a Recreation Yard at the San Diego Central Jail on 10-16-20.

Recommended Finding: Not Sustained

Rationale: On 02-27-20, Chon was arrested by the San Diego Police Department and charged with Arson, Possession of a Non-Narcotic substance, and Under the Influence of a Controlled Substance. Chon disclosed he had previously received treatment and was hospitalized for psychiatric disorders. SDCJ subsequently classified and housed Chon in a specialized Jail Based Competency Treatment (JBCT) unit. On 10-16-20, during a welfare check at approximately 6:48am, Chon made a complaint of “shortness of breath.” Inmates in this module routinely suffer from anxiety from confinement and Chon was escorted to a Recreation (Rec) Yard for some fresh air because he reportedly “did not appear to be in distress and did not request medical attention.” After Rec Yard placement, Chon stumbled then fell face down to the ground at about 6:52am. Responding deputies assessed Chon who reportedly was breathing and had a pulse. Deputies remained with Chon and called for medical response. SDCJ Medical Staff assessed Chon and then initiated life-saving measures when they discovered Chon without breath and pulse. The Fire Department assumed care until paramedics arrived and transported Chon to UCSD where resuscitation efforts were ceased and Chon was declared deceased at 7:54am. An autopsy was performed and determined the cause of death was a pulmonary embolism due to deep venous thrombosis of the left leg and an enlarged heart and liver were contributing factors to this natural death. Toxicology testing detected the presence of olanzapine (an antipsychotic drug used to treat schizophrenia) and a nasopharyngeal swab was negative for COVID-19. There was insufficient evidence to determine any different outcome had Chon been provided medical care upon his complaint of “shortness of breath (difficulty breathing).”

2. Misconduct/Procedure – Deputy 1 failed to recognize and/or respond to a medical emergency.

Recommended Finding: Sustained

Rationale: According to SDSA records, during a Safety Check and Soft Count, Inmate Chon reportedly complained of “shortness of breath.” Deputy 1 told Inmate Chon that he would contact Medical. Deputy 1 informed Deputy 3 that Chon was complaining of “shortness of breath,” continued with his checks, and never contacted Medical because he thought Deputy 3 was going to take care of Chon. Inmate Chon subsequently collapsed and died from a pulmonary embolism of which shortness of breath is a warning sign. SDSA Policy 2.3 states that employees shall be responsible for their own acts, and they shall not shift to others the burden, or responsibility, for executing or failing to execute a lawful order or duty. Furthermore, Detentions Policy M.5 mandates that all facility staff shall be responsible for taking appropriate action in recognizing, reporting or responding to an inmate’s emergency medical needs, and that emergency medical care shall be provided with efficiency and speed, and if an inmate’s condition is believed to be life-threatening, sworn staff shall immediately notify on-duty health staff. Deputy 1 provided information during CLERB’s investigation that was considered in arriving at the recommended finding, however the information is confidential per the Peace Officer Bill of Rights. Deputy 1 then exercised his option to decline participation in an interview for clarifying information pursuant to a long-standing agreement between CLERB and the Deputy Sheriff’s Association. Based upon all known information, the evidence supported the allegation and the act or conduct was not justified.

3. Misconduct/Procedure – Deputy 3 failed to recognize and/or respond to a medical emergency.

Recommended Finding: Sustained

Rationale: According to SDSA records, during a Safety Check and Soft Count, Inmate Chon reportedly complained of “shortness of breath.” Deputy 1 responded that he would contact Medical, but instead notified Deputy 3. Deputy 3 acknowledged that he was informed Chon was “having trouble breathing” and reported that inmates housed in this specific module suffer from anxiety and it is “common” (practice) for inmates to be placed in the Rec Yard for fresh air. Deputy 3 said Chon did not appear to be in any distress nor did he request medical attention. Chon was taken to the Rec Yard where he collapsed and died from a pulmonary embolism of which shortness of breath is a warning sign. Detentions Policy M.5 mandates that all facility staff shall be responsible for taking appropriate action in recognizing, reporting or responding to an inmate’s emergency medical needs, and that emergency medical care shall be provided with efficiency and speed, and if an inmate’s condition is believed to be life-threatening, sworn staff shall immediately notify on-duty health staff. Notably, Chon received medical treatment on each of the three days prior to his death. Deputy 3 provided information during CLERB’s investigation that was considered in arriving at the recommended finding, however the information is confidential per the Peace Officer Bill of Rights. Deputy 3 then exercised his option to decline participation in an interview for clarifying information pursuant to a long-standing agreement between CLERB and the Deputy Sheriff’s Association. Based upon all known information, the evidence supported the allegation and the act or conduct was not justified.

4. Misconduct/Procedure – Deputies 2 and 3 failed to provide emergency medical care to Inmate Anthony Chon

Recommended Finding: Unfounded

Rationale: Per video evidence, Inmate Chon collapsed at approximately 6:52:50. Deputies 2 and 3 entered the Recreation Yard to assess Chon at approximately 6:54:27. Chon was rolled onto his back at approximately 6:56:44, and was then placed into a “recovery” position at approximately 6:57:22. SDSA Medical Staff arrived at approximately 7:00:12 and initiated CPR at about 7:02:08; approximately 10 minutes after Chon first collapsed. Deputies reported Chon was breathing and had a pulse and they monitored him while awaiting medical response. The Detentions policy in place at the time of this incident, M.6 Life Threatening Emergencies: Code Blue, mandated that sworn staff assess the victim’s condition, call for help without leaving the victim, administer naloxone if opioid overdose was suspected, start CPR as needed, and provide the watch commander with a brief description of the incident. Video evidence confirmed deputies remained with the inmate, applied sternal rubs, rolled Chon onto his back, followed by placement into the recovery position until medical staff’s arrival. Upon arrival of a nurse practitioner (NP), she recognized Chon from previous care and called out his name, but he did not respond. The NP asked what happened and deputies reported Chon complained of “‘shortness of breath’ so they placed him on the Recreation Yard for fresh air.” When the NP assessed Chon’s condition, she saw he was not breathing and was absent a pulse

so she initiated CPR. Deputies provided information during CLERB's investigation that was also considered in arriving at the recommended finding. Deputies exercised their option to decline participation in an interview pursuant to a long-standing agreement between CLERB and the Deputy Sheriff's Association. The evidence showed that deputies were in compliance with policy and the alleged act or conduct did not occur.

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## **20-107**

1. Death Investigation/Drug Related - Omar Hasenin was found unresponsive in his cell at the George Bailey Detention Facility on 11-03-20.

Recommended Finding: Not Sustained

Rationale: On 09-04-20, Omar Hasenin was arrested by the San Diego Police Department for burglary, receiving stolen property, violation of parole and booked into the San Diego Central Jail. During the booking process, Hasenin denied any psychiatric, medical or substance abuse issues although additional medical records showed a long history of psychiatric and substance abuse issues. On 09-12-20, Hasenin was transferred to George Bailey Detention Facility (GBDF) where he was seen by jail medical and received services. Hasenin was housed in House 3, Module C (top tier) and did not have a cellmate. On 11-03-20 at approximately 03:05 pm while the bottom tier inmates had dayroom access, jail surveillance video showed several inmates crowded around Hasenin's cell. A few minutes later, an inmate ran down the stairs, where he notified the Control Deputy via intercom notification that there was a man down in cell #235. The Control Deputy initiated a radio call to floor deputies and requested medical staff to respond. About two minutes later, deputies responded and stated that they found Hasenin sitting on a desk in a slouched position, with his hands rested to his side and his eyes closed. Deputies said his skin coloration seemed normal and he was warm to touch but he was unresponsive and had no pulse. Deputies reported that they began chest compressions, which was verified by both sworn and non-sworn personnel. Several deputies and medical staff responded and performed life-saving measures to include CPR, AED, Narcan, Oxygen, etc., until paramedics arrived and took over resuscitative efforts. Hasenin showed no signs of life, and he was pronounced deceased at 03:48 pm. An autopsy confirmed the accidental cause of death was toxic effects of fentanyl with a contributing factor of atherosclerotic cardiovascular disease. Toxicology tests showed presumptive positive for fentanyl. Deputies took immediate and appropriate action as they recognized and responded to Hasenin's emergency medical needs in accordance with policy. All security checks were completed in compliance with policy as evidenced by SDSD documentation and jail surveillance video. Detectives searched Hasenin's cell and interviewed the other inmates in the module but did not find anything of evidentiary value. A few inmates stated there was "talk of fentanyl" in the module but they did not disclose any further information. (Due to jail politics, it is common for inmates not to disclose any information about illegal activity.) According to SDSD documentation, on 11-02-20, the day before the incident, there were three cell inspections supervised by command staff in House 3. According to the SDSD News Release, "Stopping Drug Smuggling in County Jails", dated 04-19-21, the SDSD is active in their attempts to intercept drugs into the facilities. Some efforts being made are the use of body scanners at all intake facilities and GBDF, inmate screening and flagging of potential smugglers. Also, the mail processing center has special equipment for drug detection, drug detection K-9's, and a "no questions asked" drug drop box. SDSD also provides drug education and awareness in the facilities. Additionally, in accordance with DSB P&P I.41, Inmate Cell Searches, cell searches were performed in an effort to provide a safe and secure environment free of contraband. Although SDSD has implemented numerous measures to deter drugs from entering its detention facilities, there is no doubt that Hasenin, while as an inmate in the custody and under the care of the SDSD, either acquired or possessed and subsequently self-administered fentanyl, which resulted in his death. Despite all interdiction efforts, fentanyl, in part, contributed to Hasenin's death, and, therefore, this death was preventable. As the investigation failed to determine how the fentanyl contributing to Hasenin's death entered the detention facility, there was insufficient evidence to either prove or disprove misconduct on the part of SDSD sworn personnel.

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## **21-019**

1. Use of Force Resulting in Great Bodily Injury – Deputies 1-6 used force to effect the arrest of Steven McCoy.

Recommended Finding: Action Justified

Rationale: According to SDCSD Records and a witness statement, on 01-11-21, around 8:30 am, Steven McCoy urinated in a flowerbed outside a business, and then confronted the reporting party with a pocket knife. Deputies responded and observed the suspect walking westbound on the street while looking over his shoulder; McCoy then dropped a methamphetamine pipe in the bushes. When contacted at gunpoint, McCoy lifted his shirt to reveal two beer cans tucked into his front waistband that he had stolen from the market. McCoy was ordered to the ground several times but did not comply. When Deputy 4 grabbed McCoy for handcuffing, Deputy 5 holstered his weapon and McCoy then displayed active resistance and assaultive behavior that prevented handcuffing. Deputies utilized hands on control, knee strikes, and baton strikes to overcome McCoy's resistance; McCoy suffered a hairline fracture of his scapula. A suspect has "no right to resist" a lawful detention. In accordance with SDCSD policies, and as documented in their reports and as observed on Body Worn Camera (BWC), deputies utilized an amount of force that was reasonable and necessary to subdue and control McCoy's non-compliant behavior. The force utilized was in accordance with law and established Departmental procedures which deputies expressed as necessary and reasonable to effect the arrest and overcome resistance when McCoy refused to comply with their lawful commands. The evidence showed the conduct that occurred was lawful, justified and proper.

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## **21-020**

2. Use of Force Resulting in Great Bodily Injury – Deputies 1 and 2 utilized force to gain compliance from Inmate William Bounds.

Recommended Finding: Action Justified

Rationale: According to SDCSD documents, Inmate William Bounds was incarcerated at the San Diego Central Jail (SDCJ) on 01-15-21. After his dayroom time had ended and at approximately 7:30am, Bounds refused to lockdown stating he did not feel safe inside his cell. Inmate Rules and Regulations, DSB O.3, requires inmates to obey staff instructions, and prohibits them from engaging in boisterous activity, and threatening or assaulting staff. Deputies 1 and 2 documented their actions in accordance with applicable use of force policies and stated Bounds stood up, faced them with clenched fists, took a fighting stance and resisted Deputy 1's efforts to control him. Deputy 1 took Bounds to the ground and attempted to move Bounds onto his chest for handcuffing, but Bounds refused to comply with verbal commands, thrashed his body about, and attempted to get up off the floor. Deputies delivered closed fist strikes to Bounds' chest and back to prevent him from standing, and applied downward pressure to Bounds' head and legs until additional deputies arrived and assisted with handcuffing the inmate. A jail surveillance video recording of the incident was reviewed and corroborated the information documented in deputies written reports, and confirmed the force utilized by Deputies 1 and 2 to subdue Bounds was necessary and reasonable to overcome his resistance. Medical records confirmed Bounds was subsequently treated for a comminuted displaced right lateral clavicular fracture. The evidence showed that the actions that occurred were lawful, justified and proper.

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## **21-026**

1. Use of Force Resulting in Great Bodily Injury – Deputy 1 used force to subdue and handcuff Christopher Brown.

Recommended Finding: Action Justified

Rationale: On the night of 02-27-21, Deputy 1 responded to a radio call in Spring Valley and consensually contacted Christopher Brown. Brown matched the description from the radio call; however, Brown declined to speak with Deputy 1 and the call was closed. Minutes later, Deputy 1 recontacted Brown in reference to illegally crossing the roadway. During the second contact, a methamphetamine pipe was observed on Brown's person in plain sight. Brown was arrested for possession of paraphernalia and was transported to

the Rancho San Diego Station for processing. While at the Rancho San Diego Station, Brown “tensed” up while being searched and turned toward deputies during a search of his person. Brown refused to comply with the deputies’ commands and resisted their efforts. In review of Deputy 1’s BWC recording, Brown and Deputy 1 were in close proximity of each other and were face to face with one another. In Deputy 1’s report, he stated that he and Brown were close enough that Brown could have easily kicked him or hit him with his head. Deputy 1 immediately used both of his hands to push Brown away from him to create distance, while he maintained positive control of him. In another deputy BWC recording, Deputy 1 was viewed to use both hands to push Brown away in the chest area. Brown’s body was pushed back, with his back hitting the cell door. Brown recovered and advanced forward and towards Deputy 1. Deputy 1 pushed Brown a second time. Deputy 1 explained that he tried to pin Brown against the cell door. When that was unsuccessful, he immediately used both hands to pull Brown’s body to the ground. Brown landed on the ground on his left side, in a semi-prone position. Deputy 1 repositioned himself and used his body weight to weigh Brown down; preventing him from standing up. Force was used to subdue and handcuff Brown. In accordance with SDSA Policy and Procedures Section 2.49 titled, “Use of Force,” Deputy 1 did not use more force than was reasonably necessary under the circumstances. Deputy 1 used force in accordance with law and established Departmental procedures and reported their use of force in writing. In accordance with SDSA Policy and Procedures Section 6.48 titled, “Physical Force,” Deputy 1, while in the performance of official law enforcement duties, was authorized and when deemed it necessary to utilize physical force, as that force was believed to be necessary and objectively reasonable to effect the arrest, prevent escape, and overcome resistance when Brown resisted. Deputy 1 utilized appropriate control techniques and tactics which employed maximum effectiveness with minimum force to effectively terminate, or afford the deputy control of, the confrontation incident. According to SDSA Policy and Procedures Addendum F titled, “Use of Force,” it shall be the policy of this Department whenever any Deputy Sheriff, while in the performance of his/her official law enforcement duties, deems it necessary to utilize any degree of physical force, the force used shall only be that which is necessary and objectively reasonable to effect the arrest, prevent escape or overcome resistance. Deputies shall not lose their right to self-defense by the use of reasonable force to effect the arrest, prevent escape, or overcome resistance. Deputies shall utilize appropriate control techniques or tactics which employ maximum effectiveness with minimum force to effectively terminate or afford the deputy control of the incident. The use of force and subsequent reporting must be in accordance with the procedures set forth in these guidelines. The investigation revealed that the force used by Deputy 1 was necessary, reasonable, lawful, justified, and proper. After the use of force, Brown was transported to the hospital where he was found to have sustained a nose fracture. It was noted in both Deputy 1’s written report, as well as deputies BWC recordings that Brown had sustained a previous facial injury prior to his contact with deputies and the subsequent use of force. In the Body Worn Camera recordings, Brown had obvious dried blood to his nose, mouth, and face, with blood stains to his sweater. Deputy 1 did not report that he struck Brown in the face. In review of the deputies’ BWC recordings, Deputy 1, nor any other was viewed to strike Brown in the face. It was unknown if the injury that Brown sustained was the result of the force used by deputies or from a previous incident.

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## **21-050**

1. Use of Force Resulting in Great Bodily Injury – Deputies 1-4 used force to subdue and handcuff Michael Ian Mallory.

### Recommended Finding: Action Justified

Rationale: On the evening of 04-15-21, a resident of Unincorporated El Cajon called the San Diego Sheriff’s Communication Center after witnessing Michael Ian Mallory climb into their yard, then climb over into a neighbor’s yard. Deputies responded to the location and contacted Mallory. During their interview with Mallory, deputies noticed that Mallory exhibited signs/symptoms of being under the influence of a controlled substance. Mallory quickly became very agitated and uncooperative with deputies. When deputies attempted to detain Mallory, he resisted their detention and attempted to run into the roadway, pulling deputies with him. A use of force ensued. During the use of force and according to Deputy 3’s report, in an attempt to stop Mallory from entering the roadway and to prevent Mallory from pulling himself and Deputy 2 with him, Deputy 3 hit both sides of Mallory’s face with a closed fist about eight times. The strikes had no

effect on Mallory; Mallory continued to fight. When Deputy 3 tried to bring Mallory's right arm behind his back, Mallory was able to pull away. According to Deputy 3's report, Mallory reached under his body with his right hand. Because Deputy 3's punches to Mallory's face had no effect, and due to the possibility that Mallory was reaching for a weapon, coupled with them being close to the roadway, Deputy 3 hit the right side of Mallory's ribcage with his left knee. Deputy 3 hit Mallory approximately three times, but Mallory continued pushing off the ground, lifting Deputy 3 with him. Deputy 3 hit Mallory with his knee one additional time. At this point, Mallory stopped trying to get up. Mallory was subdued with the use of the WRAP device. After the incident, paramedics were summoned, and Mallory was transported to the hospital to be assessed. Mallory was found to have sustained three fractured ribs, a collapsed lung, a lacerated liver, and swelling to his right cheek bone. Mallory was arrested for being under the influence while in public, prowling, and resisting arrest with minor injury to the involved deputies. In accordance with SDSD Policy and Procedures Section 2.49 titled, "Use of Force," Deputies 1, 2, 3, and 4 did not use more force than was reasonably necessary under the circumstances. The deputies used force in accordance with law and established Departmental procedures and reported their use of force in writing. In accordance with SDSD Policy and Procedures Section 6.48 titled, "Physical Force," Deputies 1, 2, 3, and 4, while in the performance of their official law enforcement duties, were authorized and deemed it necessary to utilize physical force, as that force was believed to be necessary and objectively reasonable to effect the arrest, prevent escape, and overcome resistance when Mallory resisted. Deputies 1, 2, 3, and 4 utilized appropriate control techniques and tactics which employed maximum effectiveness to afford the deputies control of the confrontation incident. According to SDSD Policy and Procedures Addendum F titled, "Use of Force," it shall be the policy of this Department whenever any Deputy Sheriff, while in the performance of his/her official law enforcement duties, deems it necessary to utilize any degree of physical force, the force used shall only be that which is necessary and objectively reasonable to effect the arrest, prevent escape or overcome resistance. Deputies shall not lose their right to self-defense by the use of reasonable force to effect the arrest, prevent escape, or overcome resistance. Deputies shall utilize appropriate control techniques or tactics which employ maximum effectiveness with minimum force to effectively terminate or afford the deputy control of the incident. The use of force and subsequent reporting must be in accordance with the procedures set forth in these guidelines. The investigation revealed that the force used by Deputies 1, 2, 3, and 4 was necessary, reasonable, lawful, justified, and proper. After the use of force, Mallory was transported to the hospital where he was found to have sustained injuries. There was no evidence to support an allegation of procedural violation, misconduct, or negligence on the part of Sheriff's Department sworn personnel.

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***End of Report***