**EXECUTIVE OFFICER**
PAUL R. PARKER III

# County of San Diego

## CITIZENS' LAW ENFORCEMENT REVIEW BOARD

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The Citizens' Law Enforcement Review Board made the following findings in the closed session portion of its May 8, 2018 meeting, held at the San Diego County Administration Center, 1600 Pacific Highway, Room 302/303, San Diego, CA 92101. Minutes of the open session portion of this meeting will be available following the Review Board's review and adoption of the minutes at its next meeting. Meeting agendas, minutes, and other information about the Review Board are available upon request or at www.sdcounty.ca.gov/clerb.

**CLOSED SESSION**

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

b) PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Notice pursuant to Government Code section 54957
Title: Executive Officer, CLERB

| DEFINITION OF FINDINGS | |
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| 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**

**16-093**

1. Death Investigation/In-Custody Suicide – On 10-29-16, while in the custody of the San Diego Sheriff's Department (SDSD) at the George F. Bailey Detention Facility (GBDF), Nicholas Helton intentionally jumped from the second tier, landing on the module floor below. Helton was transported to UCSD Medical Center where he was pronounced dead approximately 11 hours later. The cause of death was blunt force trauma of head and torso and the manner of death was suicide.

   Board Finding: Action Justified
   Rationale: The evidence indicates that prior to his booking into the SDSD jail system on 10-12-16, the arresting agency cleared him for booking through County Mental Health. Upon entry into the SDSD jail system, Helton was properly medically screened and initially placed into a Safety Cell. After psychiatric clearance from the Safety Cell, he was properly placed into the Enhanced Observation Housing (EOH) Module. After psychiatric clearance from the Safety Cell, he was properly placed into the Enhanced Observation Housing (EOH) Module. After psychiatric clearance from EOH, Helton was appropriately placed into protective custody due to his arrest charges. During his

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medical intake screening and subsequent interactions with SDSD medical personnel, to include psychiatric staff, Helton never expressed suicidal intent. There was no evidence that Helton expressed any concerns about his mental or physical wellbeing to any member of the SDSD, sworn or professional. Upon preparing to transfer to the San Diego Central Jail for extradition scheduled for the next day, Helton was allowed access to a module's unfenced second tier to give property to another inmate. Helton subsequently climbed atop the second tier railing and indicated he was going to intentionally jump from it. Deputies attempted to convince him not to hurt himself but Helton jumped from the railing a short time later, at which time they immediately initiated life-saving measures.

The transferring of property from one inmate to another inmate upon transferring from one facility to another is not expressly prohibited. The deputy who allowed Helton to gain access to the unfenced second tier was tasked with escorting Helton from the module for transfer and would not have known of his previous suicide attempt. There was no evidence to support an allegation of procedural violation, misconduct, or negligence on the part of Sheriff's Department sworn personnel and their actions were lawful, proper, and justified.

**POLICY RECOMMENDATION**:

1. It is recommended that the San Diego Sheriff's Department (SDSD) revise Detention Services Bureau Policy and Procedures Section I.47 entitled, "Inmate Wristbands and Clothing," to provide, via the identifying wristband, a visual indicator that the inmate had a prior suicide attempt.

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**17-029**

1. Misconduct/Discourtesy – Deputy 2 accused the complainant of being a child molester on April 5, 2017.

   Board Finding: Not Sustained
   Rationale: The complainant reported that he was called a sex offender by deputies and they accused him of being a child molester. Deputy 2 provided information during the course of CLERB's investigation that was considered in arriving at the recommended finding. Absent an audio recording and/or other witness testimony there was insufficient evidence to either prove or disprove this allegation.

2. Misconduct/Procedure – Deputy 2 informed the entire module that the complainant was in jail for pimping a child on April 5, 2017.

   Board Finding: Not Sustained
   Rationale: The complainant reported the entire unit was told that he was in jail for pimping on a child 14 years of age. Deputy 2 provided information during the course of CLERB's investigation that was considered in arriving at the recommended finding. Absent an audio recording and/or other witness testimony there was insufficient evidence to either prove or disprove this allegation.

3. Misconduct/Procedure – Deputy 2 allowed inmate trustee's unsupervised access to the complainant's cell resulting in some of the complainant's personal and legal property being thrown away on April 5, 2017.

   Board Finding: Action Justified
   Rationale: The complainant claimed that while at the Law Library, his cell was cleaned and his property thrown away by inmate workers. He said that Deputy 2 left two inmate trustees in his cell, unsupervised for an hour with all of his personal and legal property. The complainant reported the deputy told him, "I fucked up" and he put in a grievance, but was denied a County Claims form. Deputy 2 provided information during the course of CLERB's investigation that was considered in arriving at the recommended finding. Grievance Report #174000509 documented that a sergeant spoke with the complainant, then deputies, who described the complainant's cell as covered in trash and feces. The complainant was subsequently provided with a County Claims form by the sergeant as required by Detentions Policy Q.63 Lost Inmate Money or Property. The biohazardous materials that were disposed of for the safety of the complainant and the facility, was lawful, justified and proper.

4. Misconduct/Discourtesy – Deputy 3 laughed at the complainant while he was experiencing a seizure and stated that he hoped he died on April 13, 2017.

   Board Finding: Not Sustained
   Rationale: The complainant reported that he called "man down" because he was having an "oral." The deputy laughed in his face and told him, "I hope you have a seizure and die." Deputy 3 provided information during the course of CLERB's investigation that was considered in arriving at the recommended finding. Deployment logs confirmed Deputy

3 was working on this date and medical records specified that after the complainant was pepper-sprayed he experienced a seizure and was subsequently sent to a hospital. Absent an audio recording and/or other witness testimony there was insufficient evidence to either prove or disprove this allegation.

5. Misconduct/Discourtesy – Deputy 3 said, "Get your fake ass up nigger," while he was experiencing a seizure on April 13, 2017.

   Board Finding: Not Sustained
   Rationale: The complainant said that as he was coming out of a seizure he witnessed deputies standing over his body laughing and told him, "Get your fake ass up nigger." They also said, "If you're having a real seizure you won't remember this." Deputy 3 provided information during the course of CLERB's investigation that was considered in arriving at the recommended finding. The complainant had a well-documented history of seizure activity, but it was determined by medical staff that he also had a history of faking seizure activity. Absent an audio recording and/or other witness testimony there is insufficient evidence to either prove or disprove this allegation.

6. Excessive Force – Deputy 3 hit and kicked the complainant while he was on the ground and in handcuffs on April 13, 2017.

   Board Finding: Not Sustained
   Rationale: When asked for specific information about this allegation, the complainant responded "that was Deputy 3 at SDCJ on 4/13/17." Deputy 3 provided information during the course of CLERB's investigation that was considered in arriving at the recommended finding. Deployment logs confirmed Deputy 3 was the Fourth Floor Housing Deputy on the date of the incident. Video surveillance was reviewed and correlated to Deputy Reports after the complainant was removed from his cell and transported for medical care. However, absent recordings of the complainant's cell there was insufficient evidence to either prove or disprove this allegation.

7. Misconduct/Procedure – Deputy 1 "pig tied" the complainant and placed him in a cell for hours on April 16 and 17, 2017.

   Board Finding: Unfounded
   Rationale: The complainant said, "they pig tied a person they witnessed having a seizure. With hands behind back, (pig tie) hands and feet, and carried me down the stairs without a medical gurney (carry out bed)." Deputy 1 provided information during the course of CLERB's investigation that was considered in arriving at the recommended finding. Deployment records corroborated that Deputy 1 was working on the identified dates as a Security Deputy. However, Medical records verified that the complainant was hospitalized from April 13 through 23, 2017. The evidence showed that the alleged act or conduct did not occur. (NOTE: During CLERB's investigation, it was discovered that a situation similar to that as described by the complainant but involving different sworn personnel occurred in the beginning of May 2017. A cursory review indicated that the actions taken by sworn personnel during that situation were lawful, justified, and proper.)

8. Excessive Force/Specialty Munitions – Deputy 1 shot the complainant with plastic bullets on April 16 and 17, 2017.

   Board Finding: Unfounded
   Rationale: The complainant said that deputies came to his cell threatening to shoot him if he did not talk and he remained silent. Next thing he remembered was being shot at with plastic bullets, three to four times. Deputy 1 provided information during the course of CLERB's investigation that was considered in arriving at the recommended finding. Deployment records corroborated that Deputy 1 was working on the identified dates as a Security Deputy. However, Medical records verified that the complainant was hospitalized from April 13 through 23, 2017. The evidence showed that the alleged act or conduct did not occur. (NOTE: During CLERB's investigation, it was discovered that a situation similar to that as described by the complainant but involving different sworn personnel occurred earlier in April 2017. A cursory review indicated that the actions taken by sworn personnel during that situation were lawful, justified, and proper.)

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**17-062**

1. Death Investigation/Natural Death – On 04-25-17, while as an inmate at the Vista Detention Facility (VDF), Stephen George was found lying unresponsive in a Medical Observation Unit cell. Despite aggressive resuscitative efforts, death was pronounced while at VDF. The cause of death was acute and chronic aspiration pneumonia with an abdominal neuroendocrine tumor contributing to the death. The manner of death was natural.

Board Finding: Action Justified
Rationale: There was no evidence that George requested medical attention from any member of the SDSD, sworn or professional, above and beyond what he received (to include his refusal of offered appointments/treatment). On the morning of 04-25-17, upon being advised that George was not feeling well, sworn personnel immediately arranged for assessment/treatment by medical personnel. Later that day, after being notified George was unresponsive in his cell, sworn personnel immediately summoned assistance from medical personnel and initiated life-saving efforts. The evidence indicated that the response to the medical emergency was clearly within policy, as it was efficient and expedient. There was no evidence to support an allegation of procedural violation, misconduct, or negligence on the part of Sheriff's Department sworn personnel and their actions were lawful, proper, and justified.

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**17-111**

1. Death Investigation/Natural Death – While as an inmate at the Las Colinas Detention Re-Entry Facility (LCDRF), Barbara Antos was transported to Sharp Grossmont Hospital (Grossmont Hospital) after experiencing dizziness and exhibiting symptoms of gastrointestinal bleeding. She was diagnosed with non-traumatic gastrointestinal bleeding and, despite medical intervention, she died the next day. The cause of death was upper gastrointestinal hemorrhage, due to probable peptic ulcer disease, due to chronic nonsteroidal anti-inflammatory (NSAID) use. The manner of death was natural.

   Board Finding: Action Justified
   Rationale: There was no evidence that Antos expressed any concerns about possible gastrointestinal bleeding to any member of the SDSD, sworn or professional, prior to the day she was transported to Grossmont Hospital. Upon being advised that Antos was not feeling well, sworn personnel immediately notified medical staff and Antos was transported to Grossmont Hospital. There was no evidence to support an allegation of procedural violation, misconduct, or negligence on the part of Sheriff's Department sworn personnel and their actions were lawful, proper, and justified. As "chronic NSAID use" was listed as an underlying cause of death, it should be noted that Antos had been prescribed an NSAID while at LCDRF. The prescription of an NSAID to Antos was made by medical staff and, as such, does not fall under CLERB's jurisdiction. CLERB is noting the prescription of an NSAID for background purposes only and is not inferring the prescription contributed to the death.

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**18-062**

1. Misconduct/Procedure – La Mesa Police Department (LMPD) Officer 2 failed to file a police report regarding the complainant's allegations of a sexual assault.

   Board Finding: Summary Dismissal
   Rationale: The complainant called LMPD to file a report of a sexual assault and spoke with Officer 2. He said he called the hospital and talked with them. He called the complainant 10 minutes later and said "No worries, no crime" and hung up. The date of the incident giving rise to the complaint occurred on 11-05-16 and involved the LMPD. CLERB lacks jurisdiction per CLERB rules and regulations 4.1 Citizen Complaints: Authority and 4.4 Citizen Complaints: Jurisdiction.

2. Criminal Conduct – LMPD Officer 2 told the complainant not to worry about her complaint about the sexual assault.

   Board Finding: Summary Dismissal
   Rationale: Officer 2 told the complainant "oh yeah I know what they did don't worry I've been a witness to it before." The complainant believes this cannot be done since it is against the law. The date of the incident giving rise to the complaint occurred on 11-05-16 and involved the LMPD. CLERB lacks jurisdiction per CLERB rules and regulations 4.1 Citizen Complaints: Authority and 4.4 Citizen Complaints: Jurisdiction.

3. Misconduct/Procedure – LMPD Officer 1 and other unidentified officers said they sent the case to the District Attorney's office who said they did not receive it.

   Board Finding: Summary Dismissal
   Rationale: The complainant said Officer 1 and/or other officers stated the case was sent to the District Attorney's Office but when she contacted the DA they kept saying "No sorry we don't have it." The date of the incident giving rise to the complaint occurred on 11-05-16 and involved the LMPD. CLERB lacks jurisdiction per CLERB rules and regulations 4.1 Citizen Complaints: Authority and 4.4 Citizen Complaints: Jurisdiction.

4. Misconduct/Procedure – LMPD Officer 6 did not respond to the complainant's calls or letters.

   Board Finding: Summary Dismissal
   Rationale: The complainant stated Officer 6 never responded to any of her letters or messages. The date of the incident giving rise to the complaint occurred on 11-05-16 and involved the LMPD. CLERB lacks jurisdiction per CLERB rules and regulations 4.1 Citizen Complaints: Authority and 4.4 Citizen Complaints: Jurisdiction.

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***End of Report***

**NOTICE**

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