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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 14, 2019 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) **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).

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 (7)

ALLEGATIONS, FINDINGS & RATIONALE

16-108

1. Death Investigation/In-Custody Homicide – Lyle Woodward was attacked and strangled by a cellmate while in the custody of the Sheriff's Department at the San Diego Central Jail on December 3, 2016.

   Board Finding: Action Justified
   Rationale: The evidence supported that Woodward and his cellmates were properly classified upon their entry into the SDSD jail system after his November 3, 2016 arrest. On December 3, 2016, Woodward was last observed alive at his cell door at 12:28pm. At 12:55pm, a tower deputy was alerted by cell intercom of a "man down." Deputies and medical personnel responded to this medical emergency in accordance with Detentions Policy M.6, Life Threatening Emergencies: Code Blue and CPR was initiated at 12:59pm. CPR continued and was taken over by paramedics who regained a pulse at 1:13pm. Woodward was transported to UCSD hospital, trauma unit, where here was placed on a ventilator. Woodward later succumbed to his injuries on December 10, 2016. When deputies inquired, a cellmate reportedly stated, "We had a little fight," and bruising was observed on the inmate's right hand near and on his knuckles. It was later learned that the conflict stemmed from narcotics that had been smuggled into the jail by a third cellmate.

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While processing the scene for evidence, detectives also located two ligatures, which were consistent with a mark around the front and sides of Woodward's neck. An autopsy attributed Woodward's death to complications of resuscitated cardiac arrest due to ligature strangulation, and the manner of death was classified as homicide. Woodward's cellmate was charged and convicted of Woodward's murder. There was no evidence to support an allegation of procedural violation, misconduct, or negligence on the part of Sheriff's Department sworn personnel.

17-088

1. Death Investigation/Officer Involved Shooting – Deputy 1 shot and killed Isaias Raziel Ochoa-Bautista on 08-24-17.

   Board Finding: Action Justified
   Rationale: On 08-24-17, at approximately 1:20am, a police officer from another agency, in another jurisdiction was on routine patrol in their city when he spotted a gray Ford sedan. Initially, the vehicle was parked in the parking lot of a closed business. The police officer approached the parked vehicle to inspect it. Upon doing so, the suspect vehicle sped off. The vehicle stopped at a green light and the police officer initiated the traffic stop. The car sped off and the officer gave chase. The pursuit continued into the community of Spring Valley. Shortly after entering into Spring Valley, Deputy 1 joined into the pursuit in order to assist with the apprehension of the suspect. The pursuit continued into the City of Lemon Grove. The suspect's car eventually came to a stop in cul-de-sac and the three occupants, one being Isaias Raziel Ochoa-Bautista, ran from the vehicle. Law enforcement officers on scene saw Ochoa-Bautista jump over a fence and then heard what sounded like gunshots. A short time later they observed Ochoa-Bautista on a hillside behind a home, a short distance from the abandoned car. A K-9 handler officer from another agency arrived on scene and released his dog. The K-9 made contact with Ochoa-Bautista. While engaged with the K-9, Ochoa-Bautista fired multiple rounds from a handgun at the law enforcement officers. The four law enforcement officers, from the three different agencies returned fire, striking Ochoa-Bautista. Ochoa-Bautista was pronounced deceased at the scene and was found to be in possession of a handgun. The Medical Examiner's Office invoked jurisdiction and an examination was performed on the body of Ochoa-Bautista. The manner of death has been ruled a homicide and the cause was multiple gunshot wounds. According to a SDSD Homicide Detective's Follow-Up Investigative Report to Ochoa-Bautista's autopsy, "the fatal wound was a rifle gunshot, which struck the heart." The recovered projectile was consistent with the investigation that Deputy 1 shot only one round. Based on the facts, evidence, and the law, the use of deadly force by Deputy 1 was reasonable and does not bear criminal liability for his actions. Deputy 1 use of deadly force was appropriate, as Ochoa-Bautista's actions posed a clear deadly threat to on-scene peace officers. SDSD P&P Section 2.49 entitled, "Use of Force," states, "employees shall not use more force in any situation than is reasonably necessary under the circumstances. Employees shall use force in accordance with law and established Departmental procedures, and report all use of force in writing." SDSD P&P Section 2.50 entitled, "Use of Lethal/Less Lethal Weapons," states, "employees shall not use or handle lethal in a careless or imprudent manner. Employees shall use these weapons in accordance with law and established Departmental procedures. The applicable content of SDSD P&P Section 8.1 entitled, "Use of Firearms/Deadly Force," states, "it is the policy of the San Diego County Sheriff's Department that deputies shall use deadly force only as a last resort and only after the deputy reasonably believes that the force used is necessary: In defense of human life, including the deputy's own; or, In defense of any person in immediate danger of death, or the threat of serious physical injury. Furthermore, SDSD P&P Addendum F Section entitled, "Use of Force Guidelines," states, "Deputies shall use deadly force only after the deputy reasonably believes that the force used is necessary. Lastly, according to California PC§ 196 entitled "Justifiable Homicide by Public Officer," homicide is justifiable when committed by public officers and those acting by their command in their aid and assistance, either: 1. In obedience to any judgment of a competent Court or, 2. When necessarily committed in overcoming actual resistance to the execution of some legal process, or in the discharge of any other legal duty or, 3.

   When necessarily committed in retaking felons who have been rescued or have escaped, or when

necessarily committed in arresting persons charged with felony, and who are fleeing from justice or resisting such arrest. The facts, evidence, and perceptions of each deputy and police officer justified the use of deadly force against Ochoa-Bautista. Absent conflicting witness statements, there was no evidence to support an allegation of procedural violation, misconduct, or negligence on the part of Sheriff's Department sworn personnel.

17-129

1. Criminal Conduct – Deputy 1 used a "ruse" to enter the aggrieved's home.

   Board Finding: Summary Dismissal
   Rationale: Due to an active criminal investigation, this case is tolled and CLERB has not received any documents associated with the incident. On April 15, 2019, it was learned through media outlets, and confirmed by the Division of Inspectional Services that Deputy 1 was no longer an employee of the Sheriff's Department as of February 22, 2019. The following CLERB rules and regulations apply: 5.8 Termination, Resignation or Retirement of Subject Officer. The Review Board shall have the discretion to continue or terminate an investigation, if, after a complaint is filed and before the Review Board completes its investigation, the subject officer terminates employment with the Sheriff's Department or the Probation Department…

2. Criminal Conduct – Deputy 1 hugged the aggrieved without her consent, during which time his chest "rubbed and embraced" the aggrieved's breasts, and his hands "rubbed and fondled" the aggrieved's "torso, shoulders, arms, back, and buttocks."

   Board Finding: Summary Dismissal
   Rationale: See Rationale #1.

3. Criminal Conduct – Deputy 1 hugged the aggrieved without her consent.

   Board Finding: Summary Dismissal
   Rationale: See Rationale #1.

4. Misconduct/Procedure – Deputy 1 told the aggrieved she was "cute" and "good looking."

   Board Finding: Summary Dismissal
   Rationale: See Rationale #1.

5. Misconduct/Procedure – An unknown lieutenant and unidentified deputies failed to investigate the complainant's reports of "criminal acts against the aggrieved."

   Board Finding: Summary Dismissal
   Rationale: See Rationale #1.

18-078

1. Misconduct/Procedure – Probation Officer (PO)1 did not respond to the complainant's numerous attempts to contact him.

   Board Finding: Unfounded
   Rationale: In the complainant's statement, she advised that PO 1 did not respond to her numerous attempts to contact him. She reported, "I called PO 1 and spoke to him on [Wednesday] 08-23-17. PO 1 said he would will call me on Friday. PO1 did not call me on Friday, so I emailed him over the weekend. He never responded to me nor responded to my email." PO 1 documented his contacts with the

aggrieved and the complainant in computer generated case notes. The running log documented his, and other officer's, interactions with probationers regarding their cases. On 09-06-17, PO 1 met with the aggrieved and with the complainant for the first time in an in-person meeting. On 09-08-17, a second case note was made, as PO 1 had followed up with his aforementioned interview with both the complainant and the aggrieved. On 09-11-17, PO 1 notated a case note in which he again met with the complainant and the aggrieved and another officer in an in-person interview. Though PO 1's documented date of interview differed from the date the complainant stated, it was documented that PO 1 followed-up with the complainant and the aggrieved two days after their initial interview; on 09-08-17. Additionally, it documented that PO 1 followed-up with the aggrieved in an in-person interview on 09-11-17. There was no documentation that PO 1 had met the complainant prior to 09-08-17. Moreover, in the months that followed, either PO 1, or another probation officer, documented follow-ups/interactions with the aggrieved on 10-16-17, 10-18-17, 11-20-17. Another PO documented a follow-up phone call with the complainant on 12-27-17. There were no notes illustrating confirming or refuting that the complainant called PO 1. Lastly, San Diego County Probation Department (SDCPD) P&P Policy 400 entitled, "Supervision Duties," illustrated the frequency that a PO should interact with a probationer. The policy exemplifies that the minimum contact frequency follows for an adult is "At least two contacts per month." There were not obligatory contacts that a PO must maintain with the probationer's family members. The allegation that PO 1 did not respond to the complainant's numerous attempts to contact him was false. The evidence showed that the alleged act or conduct did not occur.

2. Misconduct/Discourteous – PO 1 treated the complainant and the aggrieved "very disrespectfully."

   Board Finding: Not Sustained
   Rationale: In the complainant's written statement, she advised that PO 1 treated her and the aggrieved "very disrespectfully." In a telephonic interview, the complainant detailed that when the aggrieved spoke with PO 1, PO 1 would not make eye-contact with him; he would roll his eyes toward the complainant. The complainant described PO 1 demeanor towards the aggrieved as "disregarded, like a non-entity, as if he did not matter." The complainant contradicted her previous statement and described PO 1 as "professional, polite, and perfect" when dealing with her, but advised that he was dismissive when dealing with the aggrieved. According to the case notes, PO 1 and other officers documented that the aggrieved had been afforded with an abundance of opportunities to engage in rehabilitation; however, he had chosen not to participate in these programs as directed. The aggrieved had displayed an unsatisfactory effort in his probationary conditions. The aggrieved had not illustrated an effort to comply with his conditions and did not seem to be interested in any rehabilitation services. The aggrieved had been on probation supervision since 2015, he had accumulated multiple warrants for simply not reporting to the Probation Department following his release from custody. PO 1 recommended the aggrieved remain in custody given his demonstrated lack of effort. As attitudes are subjective in nature and there was no evidence to support a violation of policy, there was insufficient evidence to prove or disprove the allegation that PO 1 treated the complainant nor the aggrieved in a disrespectful manner.

3. Misconduct/Procedure - PO 1 gave the complainant and the aggrieved false information.

   Board Finding: Unfounded
   Rationale: The complainant's reported that PO 1 gave her and the aggrieved false information. The complainant reported, "PO 1 also stated he would start the paperwork for transfer that afternoon and would need to see the aggrieved in person, but would go to the jail himself." Even when it was agreed upon, in person, that he would stay in touch as the aggrieved made his way to a detox program, or he tried to. It was agreed by PO 1, the aggrieved and myself, that PO 1 and the aggrieved and I would stay in contact by phone. According to PO 1 notations in the aggrieved's case file, on 09-08-17, PO 1 met with the complainant, the aggrieved, and another officer to discuss the details of the aggrieved's Interstate Compact (interstate transfer request). A senior probation officer attended the meeting to gather the information and explain the transfer process. The request to transfer was approved and PO 1 explained to the aggrieved that he must test negative for illicit drugs in order for his travel pass to be granted. The aggrieved underwent a urinalysis and tested presumptively positive for methamphetamine. PO 1 explained to the aggrieved that he would not grant him a travel pass until he was able to test clean

and would need to complete a detoxification program. On 09-11-17, PO 1 had another in-person meeting with the complainant and the aggrieved, as well as another officer to discuss Interstate Compact. Another urine analysis was submitted and again the aggrieved tested presumptively positive for methamphetamine. PO 1 directed the aggrieved to complete a detoxification program and to report to the Probation Department with his certificate of completion within two days of completing the program. On 09-11-17, in a case note in the complainant's file, PO 1 advised that he attempted to contact the aggrieved at the detoxification facility; however, he was informed by facility staff that the aggrieved never showed up for his intake. A case note in the complainant's file, reported that the offender's overall performance on probation was unsatisfactory. The aggrieved had severe substance-abuse issues that were to be addressed. The aggrieved had accumulated 11 warrants for absconding from probation supervision. The majority of his arrest involved him being in possession of controlled substances and control substance paraphernalia. After his last release from jail, PO 1 considered allowing the aggrieved to begin the transfer process as he requested to be transferred out-of- state; however, the aggrieved reported to Probation Department and tested positive for methamphetamine twice and failed to complete a period of detoxification. As such, it was recommended the aggrieved remain on probation until he was able to comply with his case and conditions. The evidence indicated that PO 1 did start the paperwork for transfer the complainant's probation out of state. As stated, the complainant also stated that "it was agreed upon, in person, that he [PO 1] would stay in touch as the aggrieved made his way to the detox program, or the aggrieved tried to. It was agreed by PO 1, the aggrieved and myself, that PO 1 and the aggrieved and I would stay in contact by phone." According to PO 1 contact case notes, PO 1 attempted to contact the aggrieved, via telephone call, while he was at the detox facility; however, he was informed by facility staff that the aggrieved never showed up for his intake. Additionally, it was noted on numerous documents through the aggrieved's case file that, "The offender last reported transient with no current or verifiable contact info." The evidence shows that the alleged act or conduct did not occur.

18-085

1. Misconduct/Medical – Medical personnel did not authorize the complainant's prescription contacts and/or eyeglasses while incarcerated causing illness and damage to her eyes.

   Board Finding: Summary Dismissal
   Rationale: The complainant reported she was booked into custody on 12-21-17 wearing monthly disposable contact lenses and her prescription had expired. She said she developed sty's (styes) on both eyes so a doctor prescribed antibiotics. The complainant was unable to wear her own eyeglasses because of their metal frames so she continued to wear the same lenses even though prolonged use of contacts can severely damage and cause long term effects. The complainant repeatedly submitted sick call requests that were unresolved to her satisfaction. A review of Sheriff's medical records documented the complainant's medical history and medical staff responses/treatment. Medical staff and their decisions reside outside of CLERB's purview as they are non-sworn personnel over which CLERB has no authority per CLERB Rules & Regulation 4.1 Citizen Complaints: Authority. The Review Board lacks jurisdiction.

2. Misconduct/Medical – Unidentified medical personnel did not follow procedure(s) when responding to the complainant's medical requests.

   Board Finding: Summary Dismissal
   Rationale: The complainant stated, "I filed and inmate grievance asking to reconsider the referral to Ophthalmology due to the situation at hand. On 2/5 I was told that it had been submitted. For the remainder of the time I was there until 4/6, I had numerous visits to Medical for recurrent eye infections and eye issues related to the contacts... I had courses of antibiotic ointments and eyedrops prescribed about 4 or 5 documented times… Nothing was changing as far as the update on my referral and I kept pleading with Medical to expedite my referral due to the recurrent infections... The more requests I would submit during these episodes, the longer it took me to see the Doctor...
   I kept trying to do things the right way and go through all the proper channels and have documentation as proof to fall back on if I was ever doubted or accused of being unreasonable for my request, but it seemed

like the procedures and policies that were in place that I kept relying on to help me and guide me, were not of any significance because nobody followed them. I just kept being told to " be patient". I think I had been since I really had no choice. It was emotionally and mentally cruel. I filed several more grievances, asking to escalate this to a higher level of command and the RN kept addressing the issue and would give me the same response stating the referral is pending. I tried to escalate this to the Facility Commander as the grievance states that we may, and once again, the RN kept writing me back saying referral pending. I felt like I was in the twilight zone with the responses I would get back from Medical on my inmate requests or grievance (of which I have full documented copies of) that wouldn't even address the questions I would ask. I tried to get a response in writing to the case manager in medical and to my counselor for the required timeframe by law that a decision of approval or denial must be made within the submission of a referral to an outside specialist and no one would give me a straight answer… I then tried grieving the grievance process because I was like what was the point of filing these when they aren't even being handled properly or heard. It seemed hopeless. Everyone I had asked for guidance or answers kept telling me the same thing, File a greivance. I was also told by a deputy that Medical is it's own entity and their grievances are handled differently." See Rationale #1

3. Misconduct/Medical – Medical personnel were "neglectful, improper, and unethical" in their treatment of the complainant during her incarceration

   Board Finding: Summary Dismissal
   Rationale: The complainant stated, "As an inmate under their supervision and care, I feel the treatment and the way overall things were handled was neglectful, improper and unethical. I did my time for what I signed for and don't feel that I deserved less than basic medical care just because I'm incarcerated. Being able to see clearly in jail shouldn't be a luxury given only under certain circumstances. A basic eye exam is something that I could of came to and got in the same day out here and I do understand that being in jail things take time, but never getting the exam, suffering from all the infections and being let down with no resolution from the only process that we are allowed to go through(grievances), seems unreal. I am seeking your help because I truly felt like I shouldn't have suffered in that way if my grievances were handled properly or if better policies and procedures were in place and hope you might be able to help." See Rationale #1

4. Misconduct/Retaliation – An unidentified deputy "rolled up" the complainant and removed her medical clearance to work in the kitchen.

   Board Finding: Action Justified
   Rationale: The complainant reported that one of the times she went to sick call she was working as a trustee in the kitchen. An RN said the complainant was unable to work in the kitchen with conjunctivitis. The complainant requested to be a "lay-in" (confined until cleared) until her eyes cleared, but upon returning to her dorm, she was instructed to "roll-up" (transfer) to another dorm. The complainant submitted a grievance believing she was being "punished by the doctor/medical out of spite." After five days of using the prescribed ointment, the complainant's eyes cleared and she returned to the previous housing unit. The complainant reported that this felt like retaliation for all the grievances/complaints she had against medical. According to WebMD, Conjunctivitis (Pinkeye) is highly contagious, spread through hand-to-eye contact, and caused by a virus, bacteria or reaction to eyedrops or contact lenses. Detentions Policy K.11, Compliance with Health Laws, mandates that Inmate Workers assigned to food handling are medically screened by the detention facility medical staff prior to performing duties in the kitchen. By law, kitchen personnel who are ill or have infections are prohibited from entering or working in the kitchen. The evidence showed that the alleged act or conduct did occur and was lawful, justified and proper.

5. Misconduct/Procedure – The complainant's confidential medical information (test result) was initially given to another inmate because of a cell number error.

   Board Finding: Not Sustained
   Rationale: The complainant reported, "I was recently incarcerated and had an HIV test done. The results

were sent back to me through the jail mail system which was slid under the cell door in the middle of the night but apparently had the wrong cell number on it and was given to the wrong inmate. A few days later the inmate came up to me and asked me if I had received the envelope that was stamped confidential. I told her I did and I asked her how she knew about it and she told me that the envelope was initially slid under her cell door had her cell number on it and she later handed it back to the deputy. The envelope that was stamped confidential had my name on it and the wrong cell written in the corner which I realized after was crossed off and my cell number was written over it and was flung under my cell door which I occupied with another inmate. I wasn't even told by the deputy that this was given to the wrong inmate by mistake or that there could have been a possible breach of confidentiality. I contemplated on addressing the issue but decided to bring it to their attention. While incarcerated you come across so many females with issues that had this been positive, I could have just imagined of what kind of traumatizing event could have occurred had this got out. I have worked in healthcare for over 10 years, and have HIPAA embedded into my head. I thought that I would be doing the right thing by addressing this issue so I filed a inmate grievance. A few days later a sergeant accompanied by another lady came to talk to me in which I explained the situation and told her what my intent was to hopefully better the process in which confidential medical information is handled. I told her I'm sure that the process in which it's being handled now could potentially violate HIPAA. She seem like she agreed and understood where I was coming from. What did concern me though during our discussion was that she had asked me if I ever received wrong mail at home and mistakes and accidents happen and also that the deputy didn't do it intentionally which I of course understood. I told her the difference between the mail that I received incorrectly at my house would be that the envelope is completely sealed, and you can stick it back in the mailbox and nothing would be revealed. I also told her that I wasn't trying to get anybody in trouble but I was hoping that they could better the process in which this was handled. She then told me that she would address this issue with Medical." The complainant's health information was processed by non-sworn personnel over whom CLERB has no authority. An error was made with the complainant's housing assignment, which was then handled by an unknown deputy. There was no purposeful intent and the sworn officer performed duties in accordance with policy to distribute mail. There was insufficient evidence to either prove or disprove the allegation.

6. Misconduct/Procedure – An unidentified sergeant failed to document the complainant's grievance(s).

   Board Finding: Not Sustained
   Rationale: The complainant reported, "I sent an email request to get a copy of the grievance that I was entitled to and to see if there was an outcome. Unfortunately after several attempts no one could locate the grievance that I had submitted or knew who the sergeant was I talk to. I was sent to medical because they thought I was trying to resolve an issue with Medical but I told them that I just needed to get a copy of my grievance. They then asked me what I wanted to do and I said I wanted to speak to a Sergeant. Later on that night two Sergeants came to talk to me and I explained the situation and asked why my grievance was nowhere to be found. Sgt X told me because probably the Sergeant that came to talk to me maybe felt like she had the situation was resolved. I asked her is it normal policy to throw away the Grievances afterwards as they're supposed to be documented and a copy kept in the inmates file. She asked what I wanted out of all this and I told her I wanted my copies back. A few days later I received a letter handed to me by a deputy from Sergeant X which whom I spoke to the second time. It stated after several attempts they do not know who it was I talked to and that they could not locate the copy of my grievance. She said that she would be handling my complaint and that she would address the issue with Medical regarding the handling of confidential mail." Sheriff's Policy N.1, Grievance Procedures allows for informal resolution of an issue before it becomes a written grievance and states that written grievances can often be resolved without the intervention of a supervisor, and that every effort should be made by a deputy or staff member who receives a grievance to handle it at his or her level. The subsequent follow-up by Sergeant X as reported by the complainant was appropriate. The initial grievance was reportedly a medical issue, which would have been routed to medical staff for resolution. There was insufficient evidence to either prove or disprove this allegation.

7. Misconduct/Procedure – The complainant's Medical Request response containing privileged information was given to another inmate because of a cell number error.

Board Finding: Not Sustained
Rationale: The complainant reported that after Allegation #5, "A few months later I submitted a request to Medical requesting to be seen for a rash that I had on my leg which took me 3 weeks to get in to be seen. Normally a copy request is sent back through mail folded in half with a little tiny piece of tape holding it down in half. I was approached by an inmate telling me that she received the copy of my inmate request for Medical back and it had the wrong cubicle number on it. At this point I had became a trustee and moved from cell living to cubicles. A few days afterwards the request was given back to me by her. I submitted another grievance furious to the fact that medically related information of mine was given to the wrong inmate by mistake due to an error again. I once again filed a grievance telling them that they really need to address this issue of how medical information is handed back to the inmates. We have a locked medical box in the chow hall and also in the dorms to where we submit these requests. I was like what was the point of having these locked boxes when on the return side they can be given out on error anyway. If they are depending on the inmate honor system to ensure these don't get read if mishandled, then there's definitely a problem there." There was no purposeful intent and the sworn officer performed duties in accordance with policy to distribute mail. There was insufficient evidence to either prove or disprove the allegation.

8. Misconduct/Procedure – Unidentified personnel failed to respond to the complainant's grievance(s), requests for HIPPA privacy rights, and/or request to file a complaint.

Board Finding: Summary Dismissal
Rationale: The complainant stated, "After waiting about 10 days I sent another request asking for a copy of my grievance and again no response. I was Furious to the fact again that I felt like it had been thrown away once more. The grievances that we submit are the only way that we are able to make any type of complaint regarding any jailhouse procedures or issues. I once again tried to address the HIPAA situation stating that I do not need nor do I want any inmate to know what I am requesting to be seen in Medical for. Depending on the nature of the request this could have been humiliating had inmates read what anyone needed to be seen for. I was just trying to advocate and I did mention that I do take my HIPAA rights seriously as they should as well. I tried submitting two more requests to get a copy of my HIPAA privacy rights at Las Colinas and also the information to where I can file a complaint and never received anything back on that. Finally, two days before I was released Sergeant X came to talk to me on one of the requests I have submitted to try to get my copy back and I gave him the rundown on the whole situation. He said within the time frame that he's been there the way that medical information has been distributed has constantly changed and unfortunately within the short time frame that I'm there nothing really can be done." This request would have been forwarded and/or responded to by medical personnel over whom CLERB does not have any authority. The Review Board lacks jurisdiction and this matter was referred to the Sheriff's Department for review.

9. Misconduct/Procedure – The Las Colinas Detention and Reentry Facility was negligent in its processes concerning the complainant's HIPPA rights.

Board Finding: Summary Dismissal
Rationale: The complainant stated, "I'm filing this complaint in hopes that someone can actually take time to review the process in which our sensitive medical information is handled and make a change to prevent error. The current process is sloppy, and with medical information in the wrong hands can be detrimental. I feel like this facility is negligent in the process and does not take our HIPAA privacy rights seriously. Being ridiculed, talked about, or questioned by any others for what my results may be or reasons I request to be seen is not of anyone's business and I don't appreciate the fact that they could care less about our right to privacy. Especially when I tried to bring this issue up previously. I filled one last grievance before I left regarding the situation and kept the yellow copies that are normally supposed to be turned in with a grievance for myself as record that I did submit the request for review as I had little faith that this was going to be addressed properly along with the email request that was given back to the incorrect inmate the last time. I have also filed a complaint with the OCR for compliance upon my release and am awaiting on the decision of their review." Medical processes are instituted and performed by non-sworn personnel over whom CLERB does not have any authority.

The Review Board lacks jurisdiction and this matter was referred to the Sheriff's Department for review.

18-088

1. Discrimination/Sexual – Deputy 2 made statements about vaginas that were overheard by the complainant.

   Board Finding: Not Sustained
   Rationale: The complainant reported, "I was in a holding cell at the Central Courthouse and was subjected to a loud, boisterous, sexually descriptive, intimidating conversation about strip searches between Deputy 2 and a younger, blonde female deputy. The younger deputy was inquisitive about strip searches, as, according to her statement, she "had performed one strip search". Deputies 1 and 2 provided information during the course of CLERB's investigation that was considered in arriving at the recommended finding. Absent an audio recording of this contact or an independent witness to this incident, there was insufficient evidence to either prove or disprove the allegation.

2. Misconduct/Discourtesy – Deputy 2 said, "How (or who) would ever want to have sex with these women (inmates)."

   Board Finding: Not Sustained
   Rationale: The complainant reported, "[Deputy] 2 made references to the ugliness of some of the vaginas she'd observed. Then she made the statement "How (or who) would ever want to have sex with these women?" Both deputies laughed and continued conversing with [Deputy] 2 making the statement: "Yeah, unfortunately, all the good one's get bailed out." This unproductive, illegal and illegal conversation lasted between 20 and 30 minutes." Deputies 1 and 2 provided information during the course of CLERB's investigation that was considered in arriving at the recommended finding. Absent an audio recording of this contact or an independent witness to this incident, there was insufficient evidence to either prove or disprove the allegation.

3. Misconduct/Procedure – Deputies 1 and 2 failed to comply with PREA (Prison Rape Elimination Act).

   Board Finding: Not Sustained
   Rationale: The complainant stated, "Sexual Harassment is a crime. And it was committed by two women who took an oath to uphold and enforce the law. Both [Deputy] 2 and her counterpart failed to comply with the Prison Rape Elimination Act as mandated by the federal government and violated numerous state and local sexual harassment/discrimination laws." The Sheriff's Department mandates a zero-tolerance policy for sexual abuse/harassment. Deputies 1 and 2 provided information during the course of CLERB's investigation that was considered in arriving at the recommended finding. There was insufficient evidence to either prove or disprove the allegation.

4. Misconduct/Retaliation – Deputy 2 forced the complainant into another holding cell after she complained.

   Board Finding: Not Sustained
   Rationale: The complainant reported, "I, the complainant caught the attention of an unidentified male deputy whose badge was not visible. I said "Please ask them to stop their inappropriate conversation. I was growing increasingly uncomfortable with their sexually explicit and derogatory remarks." I presume the male deputy spoke with [Deputy] 2 because I heard her exclaim "Inappropriate!" Upon emerging from my holding cell, [Deputy] 2 said of myself and another inmate who was not present during the said conversation, "Throw Them In There, Who Cares." and we were forced into another holding cell with the door slammed behind us." Deputies 1 and 2 provided information during the course of CLERB's investigation that was considered in arriving at the recommended finding.
   Attempts to identify the male deputy referenced by the complainant were unsuccessful and surveillance video was unavailable by the time the complainant submitted her complaint. There was insufficient evidence to either prove or disprove the allegation.

19-012

1. Misconduct/Procedure – PO 1 entered the complainant's residence without consent.

   Board Finding: Summarily Dismissed
   Rationale: In the complainant's written statement, he reported, "PO 1 entered into my home without consent in violation of California Penal Code 844. PO 1 was required to get permission to enter my place a residency and before roaming through my personal property." At the time of this incident, PO 1 was an active member of the Probation Department. On 04-02-19, it was learned, per County News, that PO 1 had retired on 02/27/19. Per CLERB Rules and Regulations 4.1, entitled, "Citizen Complaints: Authority," the Review Board shall have authority to receive, review, investigate and report on citizen complaints filed against peace officers or custodial officers employed by the County in the Sheriff's Department or the Probation Department. As such, CLERB lacks jurisdiction.

2. Misconduct/Procedure – PO 1 only made two of the three required telephonic phone calls in an attempt to contact the aggrieved.

   Board Finding: Summarily Dismissed
   Rationale: In the complainant's written statement, he reported, "PO 1 held himself above the law. Hence, instead of making at least three telephonic attempts, PO 1, total disregard for himself and all others, breach the complainant and aggrieved's residency, thus after two telephone calls. This was improper." See Rationale #1

3. Illegal Search and Seizure – PO 1 "accosted" some of the aggrieved's personal effects.

   Board Finding: Summarily Dismissed
   Rationale: In the complainant's written statement, he demanded, "Consequential, and incidentals including $3000 for stolen property. The aggrieved believed that PO 1 accosted some of his personal effects (e.g. jewelry)." See Rationale #1

Julio Estrada
Executive Officer

JFE/gv