County of San Diego

CITIZENS' LAW ENFORCEMENT REVIEW BOARD

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REGULAR MEETING AGENDA
Thursday, November 6, 2025, 5:30 p.m.
County Administration Center
1600 Pacific Highway, Chamber Room 310, San Diego, 92101

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

-AND-

Zoom Platform
https://sdcounty-ca-gov.zoom.us/j/86519024945?pwd=fzIZLNGTeK4m3RIqQS8HEbrku43KJu.1
Phone: +1 669 444 9171
Webinar ID: 865 1902 4945

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 1600 Pacific Highway, Ste. 251, San Diego, CA 92101.

1. **ROLL CALL (1 minute)**

2. **STATEMENT (just cause) and/or consideration of a request to participate remotely. (emergency circumstances) by a Board Member, if applicable. Voting item as necessary (0 minute)**

3. **PUBLIC COMMENTS (45 minutes)**

   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 a "Request to Speak" form.** Each speaker will be limited to **two minutes**; however, the time allotted for in-person, virtual and written public comment may be adjusted by the Board Chair in their discretion. This meeting will also be held remotely via the Zoom Platform. Click the link in the agenda header above to access the meeting. Contact CLERB at clerb@sdcounty.ca.gov or 619-238-6776 if you have questions.

4. **MINUTES APPROVAL (2 minutes)**

   a) Draft Meeting Minutes for October 2, 2025

5. **PRESENTATION/TRAINING** (**30 minutes**)

   a) Sheriff Kelly Martinez - SDSO

   Public Comment is 20 minutes for this item. Each speaker shall submit a Request to Speak form PRIOR to the start of the item.

6. **EXECUTIVE OFFICER'S REPORT (10 minutes)**

   a) Overview of Activities of Executive Officer and Staff

   b) Workload/Status Report – Open Complaints/Investigations Report (Attachments B)

   c) Executive Officer Correspondence to Full CLERB (Attachment C)

   d) SDSO Policy Recommendation Response to 22-056/Villasenor (Attachment D)

   e) SDSO Policy Recommendation Response to 23-079/Kuykendall (Attachment E)

7. **BOARD CHAIR'S REPORT (10 minutes)**

8. **BOARD MEMBER QUERY for SHERIFF/PROBATION LIAISON(S) (10 minutes)**

9. **NEW BUSINESS (00 minutes)**

   a) N/A

10. **UNFINISHED BUSINESS (00 minutes)**

    a) N/A

11. **BOARD MEMBER COMMENTS (10 minutes)**

12. **CLOSED SESSION: TIME CERTAIN – 7:30 pm**

    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).

CASES FOR SUMMARY HEARING (22)

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.

21-088/DOE 2101 (Probation)

1. Misconduct/Procedure – Probation Officers failed to conduct "safety checks" in compliance with policy.

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained
   Rationale: CLERB was notified of this incident in accordance with CLERB Rules & Regulations 4.3,

Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 09-08-21, at the Kearny Mesa Juvenile Detention Facility (KMJDF) "Doe 2101" died while in custody of the Probation Department. On 08-22-25, CLERB was informed the juvenile case records were sealed by Court Order. Based upon current law, there is no way for CLERB to use sealed juvenile records for use in its investigations. Due to a lack of information CLERB is unable to conduct any type of investigation. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

23-044/MARAC (DoF)

1. Use of Force Resulting in Discharge of Firearm – Deputy Benjamin Blake shot Santo K Marac on 04-23-23.

   Board Finding: Pending
   Staff Recommended Finding: Action Justified
   Rationale: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 04-23-23, SDSO received a call from roommates of Santo Marac to report he was threatening to "kill" them with a long piece of a metal bed frame. Deputy Blake responded along with two additional deputies. Deputy Blake and the additional deputies contacted Marac who was inside a bathroom with the door open. Marac was holding a piece of a metal bed frame approximately 5 feet long in a threatening manner, similar to holding a javelin. Deputy Blake and other deputies repeatedly ordered Marac to drop the metal bed frame and attempted to engage him in conversation. Marac refused and continuously held the bed frame aggressively. During the incident Deputy Blake learned probable cause existed to arrest Marac for a felony relating to threatening to kill his roommates while brandishing a weapon. Additionally, Deputy Blake learned there was another roommate still inside the residence. While additional deputies coordinated getting the roommate out, Deputy Blake attempted to de-escalate the incident to gain voluntary compliance from Marac. A PERT unit was on scene, Deputy Blake utilized communication techniques to build rapport, and multiple less lethal force options were present. Marac remained non-compliant during the entirety of the incident. Marac never put the metal bed frame down and continuously held it in a threatening manner. While attempting to effect the arrest, Deputy 2 tased Marac while Deputy Blake provided lethal cover. The taser was ineffective. Marac charged at Deputy 2 and Deputy Blake with the metal bed frame raised near his shoulders as if he was holding a javelin. Deputy Blake used his firearm and shot Marac to prevent him from assaulting Deputy 2 or himself. Per SDSO Policy Section 8.1, Use of Force/Deadly Force…*when feasible, apply de-escalation techniques before resorting to the use of a firearm. Deputies may draw, and point, a firearm when they reasonably believe, based on the totality of the circumstances, that lethal force may be necessary to defend against a threat of death or serious injury to the deputy or to another person or to apprehend a fleeing person for any felony that threatened or resulted in death or serious bodily injury, if the deputy reasonably believes that the person will cause death or serious bodily injury to another unless immediately apprehended.*. Per SDSO Use of Force Guidelines, Sections 11.9 and 11.11, deputies' use of force was appropriate and proportional to Marac's assaultive actions and active resistance. During the incident Marac consistently refused to cooperate with deputies. Marac exhibited assaultive and life-threatening behavior towards SDSO deputies by "jousting" the metal bed frame in their direction. By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

2. Misconduct/Procedure – Deputy 2 failed to employ de-escalation tactics on 04-23-23.

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained
   Rationale: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. See Rationale 1. Deputy 2 had prior experience with Marac. Approximately one month earlier, Deputy 2 arrested Marac at his residence. During that incident Marac was non-compliant. Deputy 2 volunteered to assist on 04-26-23 because of his prior knowledge. While enroute, Deputy 2 heard de-escalation efforts over the radio to include updates of *"armed with bedframe*" *"attempting to de-escalate"* and *"no change."* Prior to Deputy 2's arrival, Deputy 1 considered backing out of the residence and communicating with Marac from the outside because all the roommates were safely removed. Deputy 2 was one of the last deputies to arrive, he arrived on scene approximately 13 minutes after the first deputies arrived. Deputy 2 noticed several de-escalation tools and tactics being utilized by on

scene deputies, such as communication, canine, PERT and several less lethal force options such as bean bag, pepper ball and taser. Marac continued to be noncompliant with deputies, and the threat of great bodily injury or imminent danger was still present. Deputy 2 verified with the reporting party that probable cause existed for a felony arrest consisting of threatening to kill one of the roommates while holding the bedframe. Deputy 2 recognized deputies were attempting to affect the felony arrest through de-escalation tactics, but Marac was noncompliant, and deputies were exposed in an open hallway. Deputy 2 is a training officer on the team. Within 2 minutes of arriving on scene, Deputy 2 voluntarily took over the taser position from a deputy who had been established in that position, as well as stepped into the communication role with Marac. Deputy 2 spoke to Marac using his previous experience as an opportunity to establish rapport and gain voluntary compliance. The canine officer made suggestions to Deputy 2 based on his observations of the situation, however Deputy 2 stated he was willing to tase Marac. Deputy 2 warned Marac he would be tased and then told Marac "…*If you throw it you got nothing. Here. Here, you want to throw it? Come on,"* as he began to slowly walk towards Marac. Deputy 1 was the cover unit and followed Deputy 2. The two deputies could not gain access to a side bedroom door to get cover further exposing the deputies. Deputy 2 noticed Marac exposed more of his body and decided to tase Marac, but the taser was ineffective. Deputy 2 deployed his taser at Marac approximately 2 minutes and 37 seconds after arriving on scene. Following the taser deployment, Marac charged at Deputies 1 and 2 with the bedframe held up in a threatening manner. Deputy 1 used his firearm and shot Marac. SDSO Use of Force Guidelines Addendum F, De-Escalation, De-escalation is defined as actions taken in an attempt to stabilize an incident in order to try and reduce the immediacy of a threat by obtaining more time, tactical options or resources to resolve an incident. The goal of de-escalation is to gain voluntary compliance of subjects, when feasible, and or to potentially reduce or eliminate the need to use force on a subject. De-escalation, crisis intervention tactics and alternatives to force techniques shall be used when it is safe and feasible to do so. De-escalation does not require that a deputy risk their safety or the safety of the public De-escalation does not require a deputy risk their safety or the safety of the public. By a preponderance of the evidence, the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

3. Excessive Force – Deputy 2 deployed a taser (Conducted Energy Device) at Marac on 04-23-23.

   Board Finding: Pending
   Staff Recommended Finding: Action Justified
   Rationale: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. See Rationales 1 & 2. Marac was wanted for a felony involving threats to kill his roommates while brandishing a weapon. During the incident Marac consistently exhibited assaultive and life-threatening behavior to SDSO deputies while holding a weapon. SDSO deputies provided numerous opportunities for Marac to cooperate and warned him he would be tased. Marac continuously refused. Deputy 2 tased Marac. Section 11.18, Conducted Energy Devices (CEDs), *CEDs are an intermediate force option that may only be used to control subjects displaying assaultive behavior. Deputies shall only use the shortest duration of CED exposure that is objectively reasonable based on the circumstances. Deputies should constantly reassess the subject's behavior, reaction, and resistance before initiating or continuing the exposure.* By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

23-048/DOMINE (DoF)

1. Discharge of a Firearm – Deputy Justin Williams discharged his firearm at Gene Domine on 05-07-23.

   Board Finding: Pending
   Staff Recommended Finding: Action Justified
   Rationale: This case was reviewed in accordance with CLERB Rules & Regulation 4.3, Complaint Not Required: Jurisdiction with Respect to Specified incidents. On 05-07-Deputy Williams3, San Diego Sheriff's Office (SDSO) deputies responded to a call of a suicidal male, holding a gun to his head, inside a building at a church. Deputies were informed the suicidal male, Gene Domine, was in the "*Function Hall, not the main building*." Deputies requested the church be evacuated and were advised by dispatch, "*There's only one gate for them all to leave through so they're afraid the person with the gun would see them and start shooting."* Deputy Williams asked for ASTREA and a canine to respond but neither were available. Deputy Williams

first observed Domine in a doorway standing next to his adult grandson and made verbal contact with both. Domine's grandson followed commands to raise his hands and walk toward deputies. Domine stepped back into the doorway out of sight and reappeared with a handgun in his right hand. Deputies and church members, including Domine's grandson, began yelling at him to drop the gun. Domine walked toward the parking lot where deputies and church members were located. Domine had a cane in his left hand and the handgun in his right hand. Despite receiving more than 35 commands from deputies and church members to drop his weapon, Domine continued walking roughly 100 feet toward them. After Deputy Williams stated he did not want to shoot, Domine looked directly at him and twice shouted "*shoot*" while brandishing the handgun. Domine continued to walk into the parking lot toward deputies and church members, prompting Deputy Williams to fire one round from his rifle, striking Domine in the legs. Domine was taken into custody, treated and transported to Palomar Hospital. SDSO P & P Section 8.1 Use of Firearms/Deadly Force stated, "*It is the policy of the San Diego County Sheriff's Office that deputies shall use deadly force upon another person only when the officer reasonably believes, based on the totality of the circumstances, that such force is necessary to either: 1) defend against an imminent threat of death or serious bodily injury to the officer or to another person*." The provided evidence established that Deputy Williams was justified in defending himself, deputies, and church members by discharging his firearm. By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

2. Misconduct/Procedure – Deputy 1 failed to activate Body Worn Camera (BWC) as required by policy.

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained
   Rationale: During CLERB's investigation, it was noted Deputy 1 did not activate his BWC until after the shooting incident and while medical aid was being rendered to Domine. SDSO P&P Section 6.131, Body Worn Cameras, stated, "*The record mode of the camera should be activated prior to actual contact with a citizen ((victim/witness/suspect), or as soon as safely possible, and continue recording until the contact is complete*." Per Deputy 1's statement to investigators, he recalled attempting to activate his BWC while still in his vehicle and believed it was recording during the entire incident. Upon noticing the BWC was not recording, Deputy 1 immediately activated it. At the time of this incident, Deputy 1 had been employed with SDSO for approximately 2 months after transferring from another law enforcement agency. By a preponderance of the evidence, CLERB determined the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

23-117/BACH (Death)

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

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

Deputy 1 assisted medical staff with medication distribution. The IPs in module 4A were out in the dayroom, requiring medications to be administered via the food flap leading into the module. This necessitated that both Deputy 1 and medical staff stand outside the module, rather than visiting each cell individually. Notification to the IPs of medication distribution was made by Deputy 1 yelling through the food flap and the tower deputy making an announcement via the module intercom. Per CCTV, IPs began forming a line including Bach's 2 cellmates, who exited their cell, walked downstairs and stood in line. While medications were being distributed, Bach can be seen standing in the doorway of cell #17 but he did not leave the cell. Toward the conclusion of medication distribution, medical staff told Deputy 1 there were still people needing medication and asked him, "*Can you call out for last call for medication?"* which Deputy 1 did. Bach never showed up for his medication and medical staff never directly observed or interacted with Bach during this incident. At the conclusion of medication distribution, medical staff listed Bach as a refusal and noted Deputy 1's ID# as verification of the refusal. SDSO MSD.R.5 stated, "*Refusals for Medications: A. Patient shall sign a refusal form with the specific medication(s) being refused. B. If the patient refuses to sign the refusal form, the nurse (if available) and deputy shall sign the form. C. All refusals shall have the reason documented on the form and scanned in the medical record (when a paper form utilized J223). D. Patient should verbalize understanding of the above advice and the refusal form should be checked by the nurse. E. If the medicine is indicated for a serious medical/psych condition, refer patient to MD/RNP or psychiatrist/PRNP immediately or as soon as possible*" and "*In all instances of refusal, physicians and nurses shall document health education provided and patient's understanding of the counseling. IX. Document all encounters in the health record*." On 09-28-23, at approximately 1:08am, Deputy 2 escorted medical staff into module 4A for the purpose of administering a blood sugar check on Bach. Deputy 2 walked upstairs to Bach's cell while medical staff remained downstairs. Deputy 2 indicated medical staff requested he go upstairs to ask if Bach wanted to take his medication. During his interview, Deputy 2 described, "*Sometimes the nurses, they don't want to go upstairs so they ask some of the housing deputies, hey can you just go upstairs and ask for us instead of them physically coming upstairs*." Deputy 2 could not recall if Bach was supposed to get a blood sugar check or medication or both stating, "*In all the grand scheme it's just medication pass*." Deputy 2 observed Bach laying on the floor naked and recalled asking Bach, "*Hey, do you want to take it or not*?" Deputy 2 described Bach as "*laying down and he was gesturing like a shoo away motion with his hand*" which Deputy 2 took as a refusal. Deputy 2 further described Bach as looking, "*irritated, like he didn't want to be bothered*." During this interaction. Deputy 2 described Bach's cellmates as sleeping in their bunks. Even though he did not go upstairs with the deputy, medical staff said he could hear Deputy 2 ask three times if Bach wanted his blood sugar checked. Medical staff could hear an IP inside the cell respond "*no*" and when asked again, the IP answer "*no*" in a louder voice. Medical staff asked if Bach was refusing and the deputy confirmed he refused. When asked if medical staff was supposed to personally go to the cell instead of sending a deputy, medical staff replied, "*Now, I should probably go up and check."* When asked what the policy required, medical staff replied, *"That's probably the policy is the nurse probably has to look at him*" and clarified that normal procedure would be the nurse accompanying the deputy. Medical staff said it is common for IPs to refuse insulin at night. Medical staff never directly observed or interacted with Bach during this incident. SDSO MSD.R.5 stated, "*Refusals for Medications: A. Patient shall sign a refusal form with the specific medication(s) being refused. B. If the patient refuses to sign the refusal form, the nurse (if available) and deputy shall sign the form. C. All refusals shall have the reason documented on the form and scanned in the medical record (when a paper form utilized J223). D. Patient should verbalize understanding of the above advice and the refusal form should be checked by the nurse. E. If the medicine is indicated for a serious medical/psych condition, refer patient to MD/RNP or psychiatrist/PRNP immediately or as soon as possible*" and "*In all instances of refusal, physicians and nurses shall document health education provided and patient's understanding of the counseling. IX. Document all encounters in the health record*." On 09-28-23, at approximately 2:24am, Deputy 2 assisted medical staff with medication distribution within the module. Deputy 2 and medical staff went to Bach's cell and recorded their interaction as a refusal of medication. On 09-28-23, at approximately 2:37am, Deputy 2 and Deputy 5 conducted a safety check of the module. See allegation #7 regarding Deputy 2 and Deputy 5's safety check. On 09-28-23, at approximately 3:35am, Deputy 1 and Deputy 2 conducted a safety check of the module. While checking Bach's cell, Deputy 1 observed Bach laying naked on the floor but could not tell if he was breathing. Deputy 1 and Deputy 2 entered the cell and found Bach unconscious and not breathing. Deputies initiated CPR and requested medical assistance with a nurse arriving at the cell at approximately 3:40 am. CPR continued until Fire personnel arrived and took over. CPR and medical aid were administered until approximately 4:09 am when it was stopped and Bach was pronounced deceased. Bach's diagnosis of type 1 diabetes and use of an insulin pump was noted at

intake. Bach was prescribed 10 units of Novolin (insulin) 3 times per day at mealtimes (3:30am, 10:30am, 3:00pm). Two separate orders for blood sugar checks were made. Statcare ordered them twice a day and SDCJ medical staff ordered them 4 times per day. Bach's blood sugar was checked seven times between 3:05 am on 09-26-23 and 1:53 am on 09-27-23. Insulin was administered two times, at 4:43pm on 09-26-23 and 1:53am on 09-27-23. While housed in the X module, medical staff failed to provide Bach insulin on 09-27-23 at 10:30am. Bach was also scheduled for insulin at 3:00pm but was transitioned into module 4A at approximately 2:24pm and was not provided insulin at 3:00pm. There are no records of Bach receiving any blood sugar checks or insulin during the approximate 12 hours he was housed in module 4A. There are three records of refusals during Bach's time in module 4A for both blood sugar checks and insulin. At the time of his death, Bach had missed three consecutive administrations of insulin. Per the Medical Examiner's report, Bach's death was the result of diabetic complications. "*Based on the autopsy findings and the circumstances surrounding the death, as currently understood, the cause of death is* ***diabetic ketoacidosis*** *due to type 1 diabetes mellitus with hypertensive and atherosclerotic cardiovascular disease as a contributing condition. The death is due to complications of a natural disease. However considering the inaction (i.e., neglect) characterizing the events leading to inadequate care while incarcerated of Mr. Bach's health conditions and ultimately his death, the manner of death is classified as* ***homicide****."* Deputy 1 provided a confidential statement during CLERB'S investigation that was taken into consideration. A Department Informational Source provided a confidential statement during CLERB'S investigation that was taken into consideration. Deputy 2 provided a confidential statement during CLERB'S investigation that was taken into consideration. Per CLERB Rules & Regulations 16.1, At the conclusion of a matter before the entire CLERB, CLERB shall deliberate and adopt a final report ("Final Report") with respect to the case or matter under consideration. This report shall include Findings as to the facts relating to any case, as well as an overall conclusion as to any case as specified in Section 16.2.

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

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

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

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained
   Rationale: Per CCTV, at approximately 4:05pm, Deputy 4, in preparation for meal distribution, arrived at cell #17 and opened the food flap. Deputy 4 appeared to be in conversation with an IP within the cell, ultimately leaning into the open food flap and looking into the cell. At approximately 4:06pm Deputy 4 walked away and continued to open the remaining cell food flaps. Deputy 4 reported to detectives he could not recall the specifics of the interaction other than Bach showing him his insulin pump and telling Deputy 4 he takes insulin. Deputy 4 recalled contacting medical staff and confirming that Bach takes insulin. Deputy 4 indicated it was unusual for an IP to have an insulin pump stating, "*So when he showed that to me, I was like that's kinda weird because we don't have those in here*." In response to a question if Deputy 4 told medical that Bach needed or was out of insulin, Deputy 4 replied, "*No, if he was out of it I would have taken him, like if there was medical distress or if I felt he needed medical attention then, I would have taken him down*." Deputy 4 noted that Bach appeared to be healthy, not in distress and said he did not hear any beeping from the insulin pump. Per an interview with IP Redacted, Bach's cellmate, IP Redacted stated Bach told a deputy he was out of insulin and needed more. IP Redacted was not able to identify the deputy who Bach allegedly reported this to. SDSO DSB policy M.13 outlined who is responsible for the medical care of IPs as, "*Detention facility qualified health providers (QHP) (e.g., physicians, nurse practitioners) are primarily responsible for the medical treatment, planning, and referral to any necessary outside medical service when deemed necessary. QHPs are also responsible for providing emergency medical care and will determine additional treatment or referral to an emergency department, if needed. Within their respective scopes of practice detention facility registered nurses and licensed vocational nurses are responsible for responding and rendering emergency care and referral, logistical support of all patient/doctor activity, screening interviews, administration of medications, implementation of all physician's orders and treatment, and special programs."*

The evidence showed Deputy 4 had a conversation with Bach regarding his use of an insulin pump. What is unclear is the exact nature of the conversation. SDSO DSB policy M.5 outlined, "*All facility staff shall be responsible for taking appropriate action in recognizing, reporting or responding to an incarcerated person's emergency medical needs. In any situation requiring medical response, emergency medical care shall be provided with efficiency and speed without compromising security*. The statements from Deputy 4 and IP Redacted confirm a conversation took place regarding the insulin pump but conflict about whether a "request for insulin" was made by Bach. It was evident that that Deputy 4 did not view Bach or his circumstances as urgent or in need of emergency medical care. A Department Informational Source also provided a confidential statement during CLERB'S investigation that was taken into consideration. By a preponderance of the evidence, CLERB determines the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

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

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

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

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

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

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

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

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained

Rationale: At approximately 2:37am, Deputy 1 conducted a safety check of the module and Deputy 5 conducted a supervisor inspection check. During his check, Deputy 1 looked into cell #17, moved onto the next cell briefly before returning to cell #17 where he observed Bach lying on the floor naked. Per an interview conducted by SDSO detectives, Deputy 1 stated, "It's *not uncommon to see fully naked people in the jails"* but it was "*just kind of odd, that's why I stopped and paused a little bit and went back just to make sure everything's ok or somethings going on*." The evidence showed, while Deputy 1 was looking into Bach's cell, Deputy 5 arrived and also noted Bach was laying on the floor naked. Deputy 5 also indicated it is common to see IPs sleeping on the floor and did not consider it unusual for Bach to be naked stating, "*I was told the cells are hot in there so that might explain why he didn't have any clothes on*." Both Deputy 1 and Deputy 5 observed the "*rise and fall*" of Bach's chest and believed Bach was sleeping. Neither Deputy 1 nor Deputy 5 observed any obvious symptoms of distress. Despite seeing no signs of obvious distress, Deputy 5 and Deputy 1 spent approximately 1:32 looking into Bach's cell before determining they could see the rise and fall of his chest. The rest of their cell checks each lasted approximately 5 seconds or less. SDSO DSB Policy I.64 stated, "*Sworn staff will conduct safety checks of incarcerated persons, housing areas, holding areas and vacant cells through direct visual observation (i.e., direct personal view of the incarcerated person/area without the aid of audio/video equipment). Safety checks of incarcerated persons consist of looking at the incarcerated persons for any obvious signs of medical distress, trauma or criminal activity*." SDSO DSB Policy I.23 stated, "*At least three times per pay period, the shift watch commander is responsible for conducting an inspection of housing and operational areas. The watch commander shall perform the inspection twice on the (5) five, with at least (1) one day in between checks, and once on any day of the two on. The inspection shall be conducted in the form of a safety check paying attention to health and hygiene problems, maintenance issues, security issues and the overall condition of the facility to include all staff work areas, common areas used for access in, out and around their facility i.e. (walkways/stairs/elevators)."* Deputy 5 and Deputy 1 provided confidential statements during CLERB'S investigation that were taken into consideration. By a preponderance of the evidence, CLERB determines the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

POLICY RECOMMENDATIONS:

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

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

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

24-133/DOE 2401 (GBI)

1. Use of Force Resulting in Great Bodily Injury – Unidentified Probation Officers used unspecified force on "Doe 2401", juvenile probationer on 01-04-21.

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained
   Rationale: CLERB was notified of this incident in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 01-04-21, at the East Mesa Juvenile Detention Facility (EMJDF) a use of force incident occurred in which Doe 2401 sustained a "chipped tooth." On 08-01-25, CLERB was informed the juvenile case records could not be produced, as the Court determined CLERB does not have jurisdiction, per its review of Probation's records. Due to a lack of information and no identification of subject officer(s) CLERB is unable to conduct any type of investigation. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

24-134/DOE 2402 (GBI)

1. Use of Force Resulting in Great Bodily Injury – Unidentified Probation Officers used unspecified force on "Doe 2402", juvenile probationer on 01-25-21.

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained
   Rationale: CLERB was notified of this incident in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 01-25-21, at the East Mesa Juvenile Detention Facility (EMJDF) a use of force incident occurred in which Doe 2402 sustained a "fractured finger." On 08-01-25, CLERB was informed the juvenile case records could not be produced, as the Court determined CLERB does not have jurisdiction, per its review of Probation's records. Due to a lack of information and no identification of subject officer(s) CLERB is unable to conduct any type of investigation. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

24-138/DOE 2406 (GBI)

1. Use of Force Resulting in Great Bodily Injury – Unidentified Probation Officers used unspecified force on "Doe 2406", juvenile probationer on 08-16-21.

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained
   Rationale: CLERB was notified of this incident in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 08-16-21, at the East Mesa Juvenile Detention Facility (EMJDF) a use of force incident occurred in which Doe 2406 sustained a "laceration." On 08-01-25, CLERB was informed the juvenile case records could not be produced, as the Court determined CLERB does not have jurisdiction, per its review of Probation's records. Due to a lack of information and no identification of subject officer(s) CLERB is unable to conduct any type of investigation. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

24-140/DOE 2408 (GBI)

1. Use of Force Resulting in Great Bodily Injury – Unidentified Probation Officers used unspecified force on "Doe 2408", juvenile probationer on 01-20-22.

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained
   Rationale: CLERB was notified of this incident in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 01-20-22, at the East Mesa Juvenile Detention Facility (EMJDF) a use of force incident occurred in which Doe 2408 sustained a "nasal fracture." On 08-01-25, CLERB was informed the juvenile case records could not be produced, as the Court determined CLERB does not have jurisdiction, per its review of Probation's records. Due to a lack of information and no identification of subject officer(s) CLERB is unable to conduct any type of investigation. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

24-146/DOE 2414 (GBI)

1. Use of Force Resulting in Great Bodily Injury – Unidentified Probation Officers used unspecified force on "Doe 2414", juvenile probationer on 05-10-22.

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained
   Rationale: CLERB was notified of this incident in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 05-10-22, at the East Mesa Juvenile Detention Facility (EMJDF) a use of force incident occurred in which Doe 2414 sustained a "laceration." On 08-01-25, CLERB was informed the juvenile case records could not be produced, as the

Court determined CLERB does not have jurisdiction, per its review of Probation's records. Due to a lack of information and no identification of subject officer(s) CLERB is unable to conduct any type of investigation. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

24-151/DOE 2419 (GBI)

1. Use of Force Resulting in Great Bodily Injury – Unidentified Probation Officers used unspecified force "Doe 2419", juvenile probationer on 09-30-24.

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained
   Rationale: CLERB was notified of this incident in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 09-30-22, at the East Mesa Juvenile Detention Facility (EMJDF) a use of force incident occurred in which Doe 2419 sustained a "fractured arm." On 08-01-25, CLERB was informed the juvenile case records could not be produced, as the Court determined CLERB does not have jurisdiction, per its review of Probation's records. Due to a lack of information and no identification of subject officer(s) CLERB is unable to conduct any type of investigation. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

24-152/DOE 2420 (GBI)

1. Use of Force Resulting in Great Bodily Injury – Unidentified Probation Officers used unspecified force "Doe 2420", juvenile probationer on 12-12-22.

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained
   Rationale: CLERB was notified of this incident in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 12-12-22, at the East Mesa Juvenile Detention Facility (EMJDF) a use of force incident occurred in which Doe 2420 sustained a "nasal fracture." On 08-01-25, CLERB was informed the juvenile case records could not be produced, as the Court determined CLERB does not have jurisdiction, per its review of Probation's records. Due to a lack of information and no identification of subject officer(s) CLERB is unable to conduct any type of investigation. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

24-155/DOE 2423 (GBI)

1. Use of Force Resulting in Great Bodily Injury – Unidentified Probation Officers used unspecified force on "Doe 2423", juvenile probationer on 08-14-23.

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained
   Rationale: CLERB was notified of this incident in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 08-14-23, at the East Mesa Juvenile Detention Facility (EMJDF) a use of force incident occurred in which Doe 2423 sustained a "laceration." On 08-01-25, CLERB was informed the juvenile case records could not be produced, as the Court determined CLERB does not have jurisdiction, per its review of Probation's records. Due to a lack of information and no identification of subject officer(s) CLERB is unable to conduct any type of investigation. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

24-157/DOE 2425 (GBI)

1. Use of Force Resulting in Great Bodily Injury – Unidentified Probation Officers used unspecified force "Doe 2425", juvenile probationer on 09-14-23.

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained

Rationale: CLERB was notified of this incident in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 09-14-23, at the East Mesa Juvenile Detention Facility (EMJDF) a use of force incident occurred in which Doe 2425 sustained a "loss of two teeth" On 08-01-25, CLERB was informed the juvenile case records could not be produced, as the Court determined CLERB does not have jurisdiction, per its review of Probation's records. Due to a lack of information and no identification of subject officer(s) CLERB is unable to conduct any type of investigation. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

24-159/DOE 2427 (GBI)

1. Use of Force Resulting in Great Bodily Injury – Unidentified Probation Officers used unspecified force "Doe 2427", juvenile probationer on 10-6-23.

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained
   Rationale: CLERB was notified of this incident in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 10-6-23, at the East Mesa Juvenile Detention Facility (EMJDF) a use of force incident occurred in which Doe 2427 sustained a "loss of consciousness." On 08-01-25, CLERB was informed the juvenile case records could not be produced, as the Court determined CLERB does not have jurisdiction, per its review of Probation's records. Due to a lack of information and no identification of subject officer(s) CLERB is unable to conduct any type of investigation. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

24-176 & 24-180/BURCH (Priority)

1. Excessive Force – Deputies 1-4 used force against Christopher Hayes Burch on 09-26-24.

   Board Finding: Pending
   Staff Recommended Finding: Action Justified
   Rationale: Complainant Burch alleged that *"excessive force"* was used during his arrest and that deputies *"jumped on top of [him] smashing [his] forehead and mouth into the concrete."* Burch further alleged that a deputy "*began choking [him] around the neck with his hands"* while he was restrained during the booking process. On 09-26-24, the Fallbrook Crime Suppression Team conducted a 4th waiver search in Fallbrook. Multiple individuals were contacted, including the complainant, who identified himself with an alias. Deputies recognized inconsistencies in the complainant's identity and, after another individual identified him as Christopher Burch, deputies determined he was providing false information. Deputies attempted to place Burch under arrest. According to reports and Body Worn Camera (BWC) footage, Burch resisted by pulling away, clenching his fists, and yelling. Deputies took him to the ground after he continued to flail and kick. Deputies 1, 2, 3 and 4 worked to gain control of Burch's upper and lower body. During the struggle, Deputy 3 reported being kicked in the knee. Deputies applied hand control techniques including a rear wrist lock, body weight control, and pressure to Burch's arms and torso until he was handcuffed. Burch complained of shoulder pain. Medical personnel evaluated him on scene and Burch informed medics he had ingested *"methamphetamine"* and *"fentanyl"*. Burch was transported to a hospital where he declined medical treatment and signed a refusal of care. Burch was then transported to jail. At booking, BWC and CCTV footage showed Burch standing from a seated position and making an aggressive movement toward Deputy 1, while stating, "What! Mother fucker". Deputy 1 used an empty-hand control technique by applying pressure to Burch's shoulder and upper chest/lower neck area to guide him back into a seated position. Deputies and assisting officers maintained control until Burch stopped resisting. A spit mask was also applied. Burch was then turned over to detention deputies without further incident and placed into a sobering cell due to himself admittedly taking narcotics and his aggressive behavior. Penal Code 148.9 (a) states, *"Any person who falsely represents or identifies himself or herself as another person or as a fictitious person to any peace officer listed in Section 830.1 or 830.2, or subdivision (a) of Section 830.33, upon a lawful detention or arrest of the person, either to evade the process of the court, or to evade the proper identification of the person by the investigating officer is guilty of a misdemeanor."* SDSO P&P Section 2.49 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 Office procedures, and report all use of force in*

writing." SDSO P&P Section 11.24 After Care, states *"Whenever a subject requires or reasonably requests medical attention after a use of force incident, a deputy shall promptly provide medical attention, request medical aid, and/or transport them to an emergency medical facility when safe to do so. Medical assistance should be obtained for any subject who exhibits signs of physical distress, visible injury, alleged injury or complaint of pain, lack of consciousness, or any other reason the deputy may deem necessary, based on their training and experience. Deputies should continuously monitor a subject until a medical assessment has been provided by a trained medical professional. If a subject refuses medical attention, the refusal should be fully documented in any related reports and, whenever practicable, should be recorded or witnessed by another deputy and/or medical personnel."* A review of all available evidence, including deputy reports, BWC, CCTV footage, and medical records was conducted. The investigation showed the alleged acts did occur but were lawful, justified, and proper.

24-179/HIGGINS-RODRIGUEZ (Routine)

1. False Arrest – Deputy 2 arrested Higgins-Rodriguez on 08-14-24.

   Board Finding: Pending
   Staff Recommended Finding: Action Justified
   Rationale: Complainant Ashley Monique Higgins-Rodriguez, alleged, "*On August 14, 2024, I was wrongfully arrested based on* [Redacted]*'s fabricated allegations, despite providing video evidence that disproved misconduct on my part.*" Evidence reviewed included SDSO reports, Body Worn Camera (BWC) footage, and involved-party statements. The evidence showed that on 08-14-24, deputies responded to a residence in Imperial Beach, regarding a report of a violation of a Restraining Order (Order). Deputies interviewed Higgins-Rodriguez, and the protected party, and took statements from both. Higgins-Rodriguez was noted to have violated the Order, specifically a condition that Higgins-Rodriguez have "*no-contact*" with the protected party. After determining that Higgins-Rodriguez had violated the Order, Higgins-Rodriguez was placed under arrest for violation of the Order. SDSO P&P, Section 2.51, Arrest, Search and Seizure, stated, "*Employees shall not make any arrest, search or seizure, nor conduct any investigation or official Office business, in a manner which they know or ought to know is not in accordance with law and established Office policies and procedures.*" Further, SDSO P&P Section 6.55, Protective Orders, stated, "*Personnel will thoroughly investigate reports of violations of court issued protective orders concerning domestic violence or other civil or criminal disturbances. Emphasis will be placed on strict enforcement of these laws to ensure the victim's safety as well as compliance with the law.*" The investigation showed the alleged act did occur but was lawful, justified, and proper.

2. Misconduct/Procedure – Deputies 3 and 4 "*misinterpre*t[ed]" a Restraining Order condition for Higgins-Rodriguez, on 11-19-24.

   Board Finding: Pending
   Staff Recommended Finding: Action Justified
   Rationale: Higgins-Rodriguez also alleged, "*During this visit, the officers questioned me about 'when I'm leaving' and falsely claimed, 'there's an RO for you to keep the house clean.' This misinterpretation of the restraining order—a document already based on false claims—further highlights the department's bias.*" The evidence reviewed included BWC footage, Computer Aided Dispatch (CAD) reports, and involved-party statements. The evidence showed that on 11-19-24, a Community Service Officer (CSO) responded to a call for service regarding a report that Higgins-Rodriguez had vandalized the home of [Redacted]. There was a Restraining Order (Order) involving the protected person, and Higgins-Rodriguez, the restrained person. See Rationale #1. The protected person reported that Higgins-Rodriguez had poured salt on a vehicle and inside a home. An SDSO Sergeant called the protected person and advised that pouring salt would not constitute a crime being committed. The Order included that "*RP is to keep premises in a clean & orderly condition until she moves out.*" Deputies 3 and 4 later responded to the residence and spoke with the protected person and Higgins-Rodriguez. Deputy 4 referenced the conditions that "*You're supposed to keep this place clean*." After further investigation, no action was taken by Deputies 3 and 4. SDSO P&P Section 6.55, Protective Orders, stated, "*There are a variety of court issued protective orders that relate to a variety of situations. Penal Code Section 13710 requires law enforcement agencies to maintain a record*

of all orders issued as a result of domestic violence incidents." The investigation showed the alleged act did occur but was lawful, justified, and proper.

3. Misconduct/Procedure – Deputy 1 "*dismissed*" reports by Higgins-Rodriguez.

   Board Finding: Pending
   Staff Recommended Finding: Unfounded
   Rationale: Higgins-Rodriguez further alleged, "*Despite the police's focus on ownership, they have ignored or dismissed the following serious non-civil actions…*" The evidence reviewed included SDSO reports of incidents involving Higgins-Rodriguez dated 06-24-24, 08-24-24, 09-07-24, and 11-19-24, BWC footage, and involved-party statements. Testimony from Higgins-Rodriguez was largely focused on the protected person, who Higgins-Rodriguez was involved in a civil dispute with. See Rationales #1 and #2. The evidence showed that deputies did interact with and take statements from

24-181/GOLDWATER (Routine)

1. Misconduct/Intimidation – An unidentified deputy "threatened" Incarcerated Person (IP) Jason Goldwater on 11-07-24.

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained
   Rationale: Complainant Jason Goldwater stated, an *"unknown tall black"* deputy in the jail "*threatened"* him after Goldwater jokingly said *"Rawr"* to the deputy. The unknown deputy allegedly responded, *"How about I shoot you in the head? Would that be funny?"* Goldwater did not know the name of the deputy. Goldwater described the hallway incident as verbal only and not physical. It was an unrecorded verbal exchange and there were no witnesses to the comment. A review of SDSO records indicated no deputies matching the description provided by the complainant were working on site at the detention facility around the time the incident allegedly occurred. The investigation identified that only three deputies matching the description were on the night shift schedule. One was assigned off site and the other two worked partial shifts and were gone by 00:30am. IP Goldwater reported this contact was verbal only, not violent or physical, and would only depict two people walking down a hallway. Available BWC was reviewed but did not identify the officer or capture the incident. CCTV video of the hallway incident was not available, due to SDSO's retention schedule of six (6) months unless an unusual occurrence occurred. SDSO P&P 2.22, *"Employees shall be courteous to the public and fellow employees. They shall be tactful in the performance of their duties, shall control their tempers, exercise patience and discretion even in the face of extreme provocation. Coarse, profane, or violent language is generally prohibited. Employees shall not use insolent language or gestures in the performance of his or her duties."* Per DSB I.19.C.1, *"The Digital Video Recording System will internally save the camera footage for a period of approximately six (6) months… At the discretion of the facility commander, watch commander, or facility sergeants, unusual occurrences within the San Diego Central Jail (SDCJ) will be recorded..."* By preponderance of the evidence the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

2. Misconduct/Retaliation – An unidentified deputy placed IP Goldwater in a "*court holding*" cell as punishment.

   Board Finding: Pending
   Staff Recommended Finding: Unfounded
   Rationale: Complainant Goldwater alleged, after the comment to the "*unknown tall black"* deputy, "*Instead of taking me to the holding cells back downstairs, he put me in one of the 'Court Holding' cells by myself as apparent punishment." "I was then left in that cell for several hours before finally be taken back downstairs."* The subject deputy described by Goldwater has not been identified. See Rationale #1. SDSO records document that at 3:56am Goldwater was housed in Area 2, the booking unit holding cells. Goldwater's allegations were based on his judgment of the location and condition of the holding cell. Per SDSO correspondence, it was appropriate to place IPs in any available cell on the first and second floor for a variety of reasons, including awaiting posting bail and movement to another location. Per SDSO records Goldwater was not assigned a housing unit. He was assigned to the booking housing area of SDCJ until he was released. Per SDSO DSB Q7, "*Incarcerated persons who post bail or are in custody on solely a 'Book and*

Release' charge will not be sent to a housing unit." Section DSB 1.J*: "After the booking process is complete, the incarcerated person will be taken to the designated holding area to await the classification process. The Jail Population Management Unit (JPMU) will determine the appropriate housing assignment for each incarcerated person."* By preponderance of the evidence the investigation established that the allegation is not true.

3. Misconduct/Procedure – Unidentified deputies delayed IP Goldwater's release from custody.

   Board Finding: Pending
   Staff Recommended Finding: Unfounded
   Rationale: Complainant Goldwater alleged he was booked into jail *"around midnight"* and *"I was not bondable for whatever reason until about 7am. Bond was posted promptly by a bondsman at around 7 am, but I was then not released for several more hours, until approximately 11:30am."* Goldwater alleged, "*The Sheriff's Department purposefully delayed my release."* According to SDSO records, Goldwater was booked on 11-07-24 at 00:51am hours. A bail bondsman met with Goldwater between 4:16am- 4:25am. Goldwater's bail was received at 09:30am hours. At 11:04am his bail was posted and another warrant check was conducted. Goldwater was released from custody at 11:33am hours, 29 minutes after bail process posted. Per DSB P&P Q41, Processing of Bail Bonds, "*After the bond is accepted and validity ensured, the bond will be date stamped in an appropriate location and entered immediately in JIMS. Bail bonds will be processed one at a time while the agent stands by. This includes bonds delivered in mass" quantities."* By preponderance of the evidence the investigation established that the allegation is not true.

24-193/VASQUEZ (GBI)

1. Use of Force Resulting in Great Bodily Injury – Deputy Robert Thompson utilized his canine partner in the apprehension of Camerino Vasquez on 12-09-24.

   Board Finding: Pending
   Recommended Finding: Action Justified
   Rationale: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 12-09-24, deputies were dispatched to a report of an assault with a deadly weapon near the La Petite Academy daycare in Vista. Sheriff's dispatch broadcast that a male subject, later identified as Camerino Vasquez, was chasing a security guard and a woman with a knife. Deputies responded with lights and sirens. Deputy Thompson arrived first and was directed by witnesses toward a male matching the suspect description. Deputy Thompson reported giving multiple commands in English and Spanish for Vasquez to show his hands and get on the ground. Vasquez briefly complied then began walking toward the daycare entrance. Deputy Thompson then gave a warning before deploying his canine partner, Rico, who contacted Vasquez's right wrist. Deputy Thompson and arriving deputies detained Vasquez and recovered a knife from his waistband. Vasquez sustained multiple lacerations and puncture wounds to his right arm and wrist. Medical personnel later determined that one wrist laceration was consistent with a blade wound and not a canine bite. All witnesses and victims positively identified Vasquez as the individual involved. Deputies noted that no injuries were reported to the victims, and no property damage occurred. Vasquez was booked into jail without further incident. The evidence reflects that deputies responded to a call involving reports of an armed subject near a daycare facility, issued verbal commands, deployed a canine following noncompliance, and provided immediate medical attention to the involved individual. SDSO P&P 4.4, Apprehending Suspects with Canine states, *"A canine may be used to locate and apprehend a suspect if the canine handler reasonably believes that the individual has either committed, is committing, or threatening to commit any serious offense."* SDSO SP&P 11.11 *Use of Force Matrix states, The Use of Force Matrix is a visual representation of the various force options available in response to varying suspect actions. Deputies should continually assess and modify their response based on the totality of the circumstances. The use of force matrix is intended to serve as a general guideline and is not all inclusive. Deputies are not required to use the least intrusive degree of force possible. A deputy encountering any of these subject actions can choose a reasonable response to control the subject. Ultimately, good judgement must prevail in determining a response that is reasonable and necessary for a given situation's* P&P 11.24, Aftercare states, *"Whenever a subject requires or reasonably requests medical attention after a use of force incident, a deputy shall promptly provide medical attention, request medical aid,*

and/or transport them to an emergency medical facility when safe to do so." By a preponderance of evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

25-001/ARENAS (Routine)

1. False Arrest – Deputies 1 and 2 arrested Abril Arenas on 03-17-24.

   Board Finding: Pending
   Staff Recommended Finding: Action Justified
   Rationale: Complainant Arenas alleged she was falsely arrested for criminal threats by Deputies 1 and 2. On 03-17-24, at approximately 9:20 am, deputies responded to a radio call at a Chevron gas station in Lemon Grove. The manager called 911 and alleged Arenas threatened to "*stab her*" and "*beat her up*." This was the fourth radio call involving Arenas in the area within three hours. During a prior radio call at the same location, Arenas was admonished she was not allowed on the Chevron property due to a prior trespass advisement. Deputy 2 arrived and contacted the manager who said Arenas had followed her around the property and told her, "*I am going to stab you"* which made the manager fearful for her safety. The manager showed CCTV footage to Deputy 2 of the interaction, requested prosecution for the threats, and signed a citizen's arrest form. Deputies 1 and 2 contacted Arenas who was just off Chevron property and placed her under arrest. SDSO P&P 6.110 stated, "*If a private person has made an arrest or wants to make an arrest and requests that a deputy receive the arrestee, the deputy may accept custody if they are satisfied that the private person's arrestee committed the offense and the arrest is supported by probable cause."* By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

25-004/REYES (GBI)

1. Use of Force Resulting in Great Bodily Injury – Deputies Robert Drake Jr., Tyler Phillips, and David Wettstead, used force against Sebastien Reyes on 12-30-24.

   Board Finding: Pending
   Staff Recommended Finding: Action Justified
   Rationale: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 12-30-24, Deputy Wettstead attempted to detain Sebastien Reyes for PC 485 Misappropriation of Property after approximately twelve minutes of speaking with and running Reyes for wants or warrants. After numerous attempts to calmly convince Reyes to place his hands behind his back, Reyes fell to the ground and resisted Deputy Wettstead by pushing, biting and punching Deputy Wettstead. Deputy Drake arrived many minutes later and attempted one strike to Reyes's face but Reyes failed to comply. Deputy Phillips arrived shortly after Deputy Drake and secured Reyes's legs and then administered a conductive electronic device to Reyes's lower back. At that point, deputies were able to handcuff Reyes. Deputy Wettstead was injured during the use of force. Reyes sustained an injury and was transported to a hospital for medical treatment. According to SDSO's Use of Force guidelines, deputies' use of force was appropriate and proportional to Reyes's assaultive actions and active resistance. By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

2. Misconduct/Procedure – Deputy 1 did not activate his Body Worn Camera (BWC) in accordance with Policy and Procedure.

   Board Finding: Pending
   Staff Recommended Finding: Sustained
   Rationale: During the CLERB investigation it was determined no BWC video related to this incident existed for Deputy 1. Deputy 1 provided a confidential statement during CLERB'S investigation that was considered in arriving at the recommended finding. Per SDSO P&P 6.131, "*It is the intent of the Sheriff's Office to record all law enforcement related contacts, and other contacts deemed appropriate. When responding to a call for service, a deputy/CSO shall activate their BWC in record mode prior to arriving on scene or upon arrival and prior to exiting their patrol vehicle. In situations where activation was not accomplished prior to arriving*

on scene, those reasons shall be articulated in writing via case related report, or if no report, in CAD. Deputies/CSO's should also begin recording prior to initiating any law enforcement related contact. Deputies/ CSO's shall activate the BWC to record all law enforcement related contacts. The investigation disclosed sufficient evidence to prove the allegation by a preponderance of evidence.

25-016/SCHAPER (Routine)

1. Misconduct/Procedure – Unidentified deputies confiscated Oliver Shaper's property on 01-29-25.

   Board Finding: Pending
   Staff Recommended Finding: Unfounded
   Rationale: Incarcerated Person (IP) Oliver Schaper alleged on 01-29-25 unknown deputies took *"hundreds of new pre-stamped envelopes"* from his "*modular property"* prior to his transfer to state prison. Schaper stated when he arrived at state prison he only had *"10 pre-stamped envelopes"* in his property. CCTV and BWC video were reviewed. Schaper was seen leaving his housing unit with a flat brown paper bag. Schaper held the bag upside down and nothing fell out, contradicting his claim that he had *"hundreds of envelopes"* in his property. He was escorted to a holding area with the brown paper bag. Per SDSO correspondence, *"The IP's personal property is gathered in the module by the IP and placed in a brown bag provided by the housing unit deputies… The IPs are transported to the CDCR reception area, where CDCR staff go through the IPs' personal and modular property, and they remove excess or unapproved property before it is delivered to the prisoner."* The California Department of Corrections and Rehabilitation (CDCR) Incarcerated Person Property Matrix- Authorized Personal Property Schedule, authorizes ten (10) pre-stamped envelopes during the intake process. SDSO DSB P&P Green Sheets Q.66.G Transfer of In-Custody Individual Property, *each in-custody individual being transferred from GBDF to another facility will be escorted to the Processing area by a deputy with their face card, bedding, and brown paper bag consisting of their module property. The housing deputy will inspect the in-custody individual's module property for contraband and unauthorized items. The brown bag will have the individual's in-custody name, booking number, and destination written across the bag. Bedding will be discarded in a dirty laundry bin.* CDCR only authorizes 10 pre-stamped envelopes during intake, any unauthorized property would have been disposed of by CDCR personnel. By preponderance of the evidence the investigation clearly established that the allegation is not true.

End of Report