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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 March 6, 2025, meeting held in person. **Any changes or additions to staff's recommended findings are bolded in red.** Minutes of the open session portion of this meeting will be available following the Review Board's review and adoption of the minutes at its next meeting. Meeting agendas, minutes, and other information about the Review Board are available upon request or at www.sdcounty.ca.gov/clerb.

CLOSED SESSION

a) PUBLIC EMPLOYEE DISCIPLINE/DISMISSAL/RELEASE

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

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

CASES FOR SUMMARY HEARING (16)

ALLEGATIONS, BOARD FINDINGS & RATIONALES

22-106/BAGDASARIAN (Death)

1. Death Investigation/Barricade – William Bagdasarian set fire to his unattached garage and was later discovered by deputies with a self-inflicted gunshot wound on 08-19-22.

   Board Finding: Action Justified
   Rationale: On 08-19-22, deputies were dispatched to a 911 call reporting William Bagdasarian starting a fire in the garage and making suicidal threats. No one else was inside the home. Deputies attempted to first contact Bagdasarian prior to the Bomb/Arson Unit sending in an unmanned robot to confirm Bagdasarian was deceased. An autopsy determined the cause of death to be a perforating gunshot wound of head and the manner of death was suicide. Toxicology testing detected the presence of cannabinoids in his blood. There was no evidence of foul play. A family member provided consent for SDSO to enter the residence. Deputies were in compliance with SDSO policies for 6.38-Special Enforcement Detail (SED), 6.111-High Risk Entries, and 9.3-Crisis Negotiations. There was no evidence to support an allegation of procedural violation or misconduct on the part of Sheriff's Department sworn personnel.

AYE: 6
ABSENT: 1
NAY: 0
ABSTAIN: 0

22-124/VOGELMAN (Death) **DEFERRED**

22-136/BONIN (Death)

1. Death Investigation/In-Custody Medical – Incarcerated Person Aaron Daniel Bonin was found unresponsive in his cell at the San Diego Central Jail (SDCJ) on 10-24-22.

   Board 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. Incarcerated Person (IP) Aaron Bonin was a 43-year-old white male, transferred from Patton State Psychiatric Hospital on 09-01-22, pending court proceedings for gassing a peace officer, assault with a deadly weapon, and battery on emergency personnel. Bonin was classified as a high-level, administrative separation, green banded IP who was housed on the 7th floor of SDCJ. Bonin had a long history of medical problems and was properly classified per DSB Policy R.1, which states an incarcerated person's initial classification is determined by their original booking charges, criminal history information, medical and psychiatric issues or additional special conditions, and information obtained from the incarcerated person interview. While in custody, Bonin was evaluated and treated for several documented medical and mental health concerns, which were identified upon his transfer from Patton State Hospital. Bonin was referred multiple times to local hospitals for acute care but was often non-compliant with his medications and treatment. On 10-24-22, video evidence and SDSO documentation confirmed that safety and security checks were completed in a timely manner, and at approximately 3:20am, Bonin was found unresponsive in his cell. Cardiopulmonary Resuscitation (CPR) was administered by deputies until an automated external defibrillator (AED) was utilized and 911 activated with fire personnel and paramedics responding to perform advanced cardiovascular life support for approximately 45 minutes prior to transport to a hospital. Bonin was intubated throughout his stay at UCSD Medical Center. His overall prognosis was poor and on 11-01-22, Bonin's family elected to compassionately extubate, and his death was pronounced. By a preponderance of the evidence, CLERB determines the investigation proved the actions taken were lawful, justified and proper.

2. Misconduct/Procedure - Unidentified deputies housed IP Bonin in a cell with an inoperable intercom and failed to conduct 30 minute security checks.

   Board Finding: Sustained
   Rationale: Through the course of investigation it was discovered that the intercom in Bonin's cell was inoperable on 10-24-22, following his medical emergency. SDSO records confirmed a maintenance work order was submitted on 09-13-22 for repair of the intercom in 7D, cells 8 and 9. Maintenance and repairs at the detention facilities are conducted by nonsworn personnel. Sheriff's records verified this order was completed on 09-15-22. Additionally, maintenance staff worked on the module intercoms going on and off from 09-19-22 until resolving the issue around 11-09-22. According to DSB Green Sheet, I.61.C.2, Safety Checks of Housing Units and Holding Cells, dated 04-15-22, Sergeants assigned to the movement or security position will visually inspect each touchscreen once per shift to insure proper function. This will be documented in the notes section of the JIMS Supervisor Log Review entry. Maintenance and SDCJ administrative notification will be required for any intercom found not in working order. If an intercom is found not to be operable, the cell will be placed out of service until the intercom is fixed. 30-minute safety checks will be required if any incarcerated person is placed in a cell with an identified inoperable intercom and the watch commander will be immediately notified. SDSD personnel reported that IPs are routinely not placed into cells with inoperable communication systems. According to SDSO records, Bonin was placed into Cell09 on 09-25-22 with security checks conducted every 60 minutes. It could not be verified when Bonin's intercom became inoperable again following repair, or when/if 30 minute security checks were required. There was sufficient evidence to prove that unidentified deputies housed IP Bonin in a cell with an inoperable intercom and failed to conduct 30 minute security checks.

AYE: 4
ABSENT: 1
NAY: 2
ABSTAIN: 0

23-019/SHUEY (Death)

1. Death Investigation/In-Custody Medical – Incarcerated Person Robert Shuey was found unresponsive in his single person cell at San Diego Central Jail on 02-21-23.

Board Finding: Action Justified
Rationale: According to SDSO records, on 02-20-23, IP Shuey was involved in a motor vehicle accident in Oceanside. Shuey was transported to a hospital for evaluation and tested positive for COVID. Shuey was medically cleared and transported to San Diego Central Jail under suspected DUI charges on 02-21-23. Shuey was placed into a single occupancy room in the quarantine ward of the facility and placed on Alcohol Withdrawal protocol. Video evidence and SDSO documentation confirmed that safety and security checks were conducted, and while performing a routine welfare check at approximately 8:09pm, deputies found Shuey unresponsive and initiated cardiopulmonary resuscitation. Paramedics arrived on scene and despite resuscitative attempts, Shuey could not be revived, and his death was pronounced at the detention facility. No evidence of alcohol or illicit drugs was observed in the cell. The Medical Examiner's Office determined Shuey's cause of death was "cardiopulmonary arrest due to hypertensive atherosclerotic cardiovascular disease with cardiomegaly, with type II diabetes mellitus, SARS-COV-2 (COVID-19) infection, and chronic alcoholism as contributory factors, and the manner of death is natural." By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions taken by involved personnel were lawful, justified and proper.

AYE: 6
ABSENT: 1
NAY: 0
ABSTAIN: 0

23-046/ADAMSON (Death)

1. Death Investigation/In Custody Medical – Incarcerated Person (IP) Patricia Adamson experienced a medical emergency while housed at Las Colinas Detention Reentry Facility (LCDRF) on 05-03-23.

   Board Finding: Action Justified
   Rationale: Adamson was arrested by San Diego Police Department on 02-13-23 for vandalism charges and a probation hold. Upon booking, Adamson was classified as a Level 4-High Incarcerated Person (IP) and placed into a sobering cell. On 02-15-23, Adamson was transported to a hospital for vomiting and returned to custody a few days later. Adamson was housed in the Women's Psychiatric Stabilization Unit (WPSU) for a few months, until cleared and moved into an Outpatient Step Down Unit on 04-27-23. On 05-03-23 during a safety and security check at approximately 8:15 am, a deputy noted a "psychological decline" in Adamson and contacted medical for assessment. Medical arrived as deputies transported Adamson to the shower later that day. Deputies noticed the IP had blood around her mouth and 911 was activated. Deputies placed Adamson in the recovery position, who continued to throw up blood. Medical responded to the scene and performed life saving measures. Paramedics also arrived and continued life saving measures, but Adamson died on scene. An autopsy was performed and determined the cause of death was complications of hiatal herniation of the transverse colon with contributing factors of chronic obstructive pulmonary disease; hypertensive cardiovascular disease and the manner of death was natural. According to SDSO DSB P&P, Section M.5 Medical Emergencies, all facility staff shall be responsible for taking 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. If the incarcerated person's condition is believed to be life threatening, sworn staff shall immediately notify on-duty health staff and provide basic life support (BLS) and/or first aid care. Pursuant to policy, Adamson was classified properly. Safety and security checks were also conducted within policy. 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 respond to Adamson's medical emergency.

   Board Finding: Action Justified
   Rationale: On 05-03-23, Deputy 1 was assigned as the floor deputy in Adamson's module. Deputy 1 performed a safety and security check at 8:15am and stated Adamson had "declined psychologically." Deputy 1 contacted medical that morning and asked for an assessment. Later that day at approximately 12 pm, Deputy 1 entered Adamson's cell and witnessed when she emitted a brown substance from the side of her mouth, which was described as coffee grounds by the deputy. Deputy 1 escorted Adamson to the shower in a wheelchair. When deputies escorted Adamson to the shower, two medical staff personnel were already present in the module and

aware that Adamson had thrown up earlier that day. Medical staff were waiting to assess Adamson when she had the medical episode and additional medical staff responded. According to SDSO DSB P&P, Section M.5 Medical Emergencies, all facility staff shall be responsible for taking 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. Deputy 1 acted in accordance with policy, as she contacted medical that morning when she saw a concern with Adamson's mental/physical health. Also, SDSO DSB P&P, Section M.6 Life Threatening Emergencies: Code Blue states any life-threatening medical emergency shall trigger a 911 request for a paramedic emergency response team. In addition, health staff responding to a code blue shall manage the emergency response, monitor IPs status continuously and delegate as necessary. Deputy 1 responded in accordance with policy and procedure. By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

3. Misconduct/Procedure – Unidentified staff failed to sanitize Adamson's cell.

   Board Finding: Not Sustained
   Rationale: Complainant Paloma Serna alleged Adamson lived in "awful conditions" and a "filthy cell." Jail medical staff stated on 02-27-23 Adamson's cell was noted to be "extremely filthy with feces, and vomit on the floor and toilet seat" but the IP refused to change cells, and the IP was "too hostile" to continue cleaning the cell. Deputies would "take advantage" of Adamson's cooperation and would move her to a clean cell. Jail medical staff also stated Adamson's cell would become full of trash within one day and she often refused to cooperate with trash collection. Adamson was housed in House 5 for seven days, where she remained in cell #12. There was daily activity of Covid Cleanup/Disinfecting, which consisted of IP workers cleaning the common areas and picking up trash from cells. However, SDSO documentation did not show that trash was collected from Adamson's cell. Per Body Worn Camera dated 05-03-23, Adamson's cell was in disarray, full of trash and had a brown substance on the floor, but it was unknown how long the cell was in that state. According to SDSO DSB LCDRF Green Sheets, Section L.2.L Sanitation and Hygiene Inspections states, absent exigent circumstances, weekly sanitation and hygiene inspections will be conducted throughout the facility on Friday nights. During hygiene inspections, deputies will ensure the cleanliness, safety and security, and maintenance of the cell/cubicle and housing area. If deputies are unable to enter the cell to complete a hygiene inspection, due to an IPs refusal to exit, the IP may be extracted at the direction of the watch commander. Adamson had a history of not cooperating with cell clean up and filling her cell with trash within a day's time. 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 - Unidentified staff failed to log a hygiene inspection at LCDRF.

   Board Finding: Not Sustained
   Rationale: Through the course of this death investigation, CLERB discovered a weekly hygiene inspection was not documented in the Jail Information Management System (JIMS), as mandated by policy. SDSO DSB LCDRF Green Sheets, Section L.2.L Sanitation and Hygiene Inspections, states, absent exigent circumstances, (emphasis added) weekly sanitation and hygiene inspections will be conducted throughout the facility on Friday nights. During hygiene inspections, deputies will ensure the cleanliness, safety and security, and maintenance of the cell/cubicle and housing area. In addition, a hygiene form will be completed for each module inspection and documented in JIMS under event type "Inspection." Although there was daily activity of Covid Cleanup/Disinfecting by IP workers, which included the cleaning of common areas and trash pickup inside of cells, this does not replace the mandated weekly hygiene inspections. The Watch Commanders Log dated 05-03-23 showed that all inspections were completed. 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 – Unidentified deputies failed to provide Adamson with a shower.

   Board Finding: Unfounded
   Rationale: Complainant Paloma Serna alleged, "We don't know how long she (Adamson) did not bathe." Adamson's medical records were reviewed and considered for the recommended finding. Title 15 Minimum Standards for Local Detention Facilities, Article 13, §1266. Showering states, Incarcerated persons shall be

permitted to shower/bathe upon assignment to a housing unit and at least every other day or more often if possible. SDSO DSB LCDRF Green Sheets, Section L.11.L Personal Hygiene states that offers to shower will be logged into JIMS in housing units where access to the shower is restricted. SDSO documentation verified that Adamson was offered showers while she was in WPSU in accordance with Title 15. Adamson often refused to shower, and it was unknown when her last shower occurred, but IPs in the module had dayroom/shower access on a daily basis. By a preponderance of the evidence, CLERB determines the investigation disclosed sufficient evidence to prove the allegation did not occur.

6. Misconduct/Medical – Unidentified staff failed to provide Adamson adequate medical care.

   Board Finding: Summary Dismissal
   Rationale: Complainant Paloma Serna alleged, "Medical staff decided not to treat or send Ms. Adamson out to the local hospital." Adamson was housed in Women's Psychiatric Stabilization Unit (WPSU) for the majority of her stay at LCDRF. According to SDSO MSD Operations Manual Section MSD.P.8 Psychiatric Stabilization Unit, a patient shall be admitted to the PSU upon the direct order of a Detentions Psychiatrist or the San Diego County Psychiatric Hospital. Patients admitted into the PSU shall meet the criteria as defined by the California Welfare and Institutions Code 5150 as an involuntary or a voluntary patient needing acute psychiatric care. All patients admitted to the PSU shall have an initial history and physical completed upon admission and access to medical care as needed. Adamson was properly classified/housed in specialized housing/WPSU where health staff are responsible for ongoing medical evaluation and treatment. CLERB Rules and regulations state that CLERB shall have authority to receive, investigate and report on complaints against custodial officers employed by the County in the Sheriff's Department. CLERB does not have jurisdiction over the subject matter of the complaint.

AYE: 6
ABSENT: 1
NAY: 0
ABSTAIN: 0

23-054/BARTOLACCI (Death)

1. Death Investigation/In-Custody Medical – Incarcerated Person Roselee Ann Bartolacci died while in the custody of the San Diego Sheriff's Office (SDSO) on 05-29-23.

   Board Finding: Action Justified
   Rationale: IP Bartolacci was incarcerated at the Las Colinas Detention and Reentry Facility (LCDRF) after her 04-06-23 arrest. Bartolacci was a psychiatric patient and housed alone in the jail's Psychiatric Stabilization Unit (WPSU/PSU). According to jail documents, safety/security checks were performed in accordance with SDSO policy and procedures. According to SDSO DSB P&P Section I.64 titled "Safety Checks: Housing and Holding Areas of Incarcerated Persons," safety checks in the PSU shall be conducted at least once within every 30-minute time period. A review of safety checks noted all were performed within the 30-minute time period. At approximately 11:34pm, following a safety check by Deputy 2, Deputies 1 and 2 and a nurse entered the cell and found Bartolacci unresponsive, lying on her back, mouth agape, eyes open, and without a pulse. The nurse immediately initiated basic lifesaving measures by procuring an AED device and soon thereafter chest compressions with oxygen. Additional jail medical staff and paramedics were summoned to the scene. Upon paramedic's arrival on scene, they continued administering advance cardiac lifesaving measures until Bartolacci's death was pronounced. Bartolacci's cause of death by the San Diego County Medical Examiner's Office was determined to be "complications of dilated cardiomyopathy, with obesity being a contributing factor and the manner of death is natural." The evidence indicated Bartolacci was properly classified upon her entry into the SDSO jail system. There was no evidence that Bartolacci expressed any concerns for her mental or physical well-being to any member of the SDSO, sworn or professional. By a preponderance of the evidence, CLERB determines the investigation proved the actions taken were lawful, justified and proper.

2. Misconduct/Procedure – Deputy 1 failed to provide emergency medical care to Bartolacci.

   Board Finding: Not Sustained

Rationale: While conducting a safety/security check on Bartolacci, a Nurse asked Deputy 1 to assist in entering Bartolacci's jail cell. Together, they found Bartolacci lying on her back, unresponsive, mouth agape, eyes open, blue lips and no pulse. The nurse exited the jail cell to retrieve an AED machine while Deputy 1 remained in the cell next to Bartolacci. The nurse returned with the AED in approximately 28 seconds and placed the AED pads on Bartolacci. Following the AED alerting to start CPR, Deputy 2 began chest compressions. SDSO DSB P&P Section M.5.B "Medical Emergencies," states, "When the severity of the medical emergency requires it, and as soon as it is safe to do so (unless death is obvious, such as decapitation, obvious rigor mortis, etc.), deputies acting as first responders will provide basic life support and first aid. Upon arrival, facility health staff will assess the severity of the person's injury/distress, provide first-aid, and may assist or take over cardiopulmonary resuscitation (CPR) responsibilities, until relieved by 911 personnel (paramedic emergency response team)." DSB P&P Section M.6.B.4 titled "Life Threatening Emergencies," states, "Start cardiopulmonary resuscitation (CPR) as needed using a barrier device (e.g., PAM mask, pocket mask). Additional resuscitative equipment will be provided by health staff. Health staff will determine the appropriateness of utilizing additional emergency equipment including, but not limited to, the Automated External Defibrillator (AED). In circumstances, or locations, where response time from health staff may be delayed (e.g., the public visit lobby), a deputy may determine the appropriateness of utilizing additional medical equipment such as the AED." M.6.C states, "Health Staff responding to a code blue shall: Respond to the scene with the appropriate emergency equipment. 1. Assess the situation immediately. 2. Manage the emergency response and monitor the victim's status continuously. 3. Delegate as necessary. In addition to sworn staff, any health staff, including a medical doctor (MD), registered nurse practitioner (RNP), registered nurse (RN) or licensed vocational nurse (LVN) has the authority to call 911 or other medical transport for any medical condition they deem necessary. If health staff calls 911, notification shall be made to the watch commander or designee." When asked by homicide detectives if Deputy 1 provided medical aid, Deputy 1 responded, "no, I was waiting for the nurse to return with the AED." Deputy 1 also provided a confidential statement to CLERB that was considered in arriving at the recommended finding. While Deputy 1 did not begin CPR while the nurse retrieved the AED device as directed by policy, the policy also states the deputy is not the first responder when health staff are on the scene as M.5 and M.6 suggest. By a preponderance of the evidence, CLERB determines the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

AYE: 4
ABSENT: 1
NAY: 2
ABSTAIN: 0

23-080/MCDOWELL (Death)

1. Death Investigation/In-Custody Suicide – Incarcerated Person Jonathan Wesley McDowell, while in the custody of the San Diego Sheriff's Office, was discovered hanging in his cell on 07-19-23 and subsequently died at a hospital on 07-29-23.

   Board Finding: Action Justified
   Rationale: McDowell was under the custody of SDSO, incarcerated at the George Bailey Detention Facility (GBDF). On 07-19-23, at 9:45am McDowell underwent a routine medical welfare interview/evaluation by a Qualified Mental Health Practitioner and a sergeant. At the time of the welfare check, McDowell reported that he felt "fine." Approximately ten minutes later, at 10am, a housing deputy performed a safety/security check at McDowell's jail cell. McDowell was without complaint. At 10:18am, McDowell's cellmate alerted deputies of a "man down." Deputies arrived at the jail cell and found McDowell unresponsive and hanging by a makeshift noose fastened around his neck. Deputies and jail medical/health staff performed life-saving measures. Paramedics were summoned and, upon their arrived, they took over life-saving attempts. McDowell was transported, to a local trauma hospital where he was diagnosed with a brain injury and was placed on life support. On 07-27-23, McDowell's family elected comfort care measures, and his health declined until his death, which was pronounced on 07-29-23. The evidence supported that McDowell was properly classified upon his entry into the SDSO jail system after his arrest. During his medical intake screening with SDSO medical personnel, to include psychiatric staff, McDowell never expressed suicidal ideations or intent. Upon being advised that McDowell was found hanging in his cell, sworn staff expeditiously responded and immediately initiated life-saving measures. The Medical Examiner's Office determined McDowell's cause of death was "Asphyxia due to Hanging," and the manner of death was Suicide. By a preponderance of the evidence, CLERB

determines the investigation proved the alleged actions were lawful, justified and proper.

AYE: 5
ABSENT: 1
NAY: 1
ABSTAIN: 0

24-044/LOONEY (GBI)

1. Use of Force Resulting in Great Bodily Injury – Deputies Dominic Banaga, Robert Biesel, and Zachary Dalton utilized force to arrest Jeremiah Looney on 02-11-24.

   Board Finding: Action Justified
   Rationale: CLERB Rules and Regulations Section 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents, states CLERB shall have authority to review, investigate, and report on the use of force by peace officers employed by the San Diego Sheriff's Office (SDSO) resulting in great bodily injury. CLERB was notified of use of force resulting in great bodily injury occurring on 02-11-24. SDSO reports and BWC showed SDSO deputies used a canine in the apprehension of a felony wanted subject, Jeremiah Looney, which ultimately resulted in Looney sustaining an injury. The evidence showed Looney was a fleeing suspect wanted for felony crimes. According to deputy body-worn camera (BWC) footage, Looney failed to comply with lawful orders, which led to the deployment of a Sheriff's canine. BWC footage showed Looney actively resisting by failing to remove his hands from underneath his body. Deputies ultimately were able to secure Looney in handcuffs using physical control techniques. The evidence showed the force used was within SDSO P&P. By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

2. Excessive Force - Deputies 1, 2, and 3, "kneed" Looney and did not release a canine from Looney's arm.

   Board Finding: Action Justified
   Rationale: On 04-04-24, CLERB received a signed complaint from Jeremiah Looney who alleged he was the victim of excessive force. Complainant Looney stated the SDSO canine "wouldn't listen to [Deputy 1], so the K-9 Deputy had to use a Breaker Stick to pry the dog's jaws off me." The evidence showed, after Looney was secured in handcuffs, Deputy 1 used a department-issued "breaker stick" to release the canine from Looney's arm. Deputy 1's use of the breaker stick was in accordance with California Peace Officer Standards and Training (POST) K-9 Guidelines. Additionally, complainant Looney stated, "That's when other deputies jumped on me smashing three knees into my head to the concrete[sic]." BWC footage captured the force used by Deputies 1, 2, and 3, and did not show deputies 'smashing three knees' into Looney's head. See Rationale #1. The evidence showed the force used was within SDSO P&P. By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

3. Misconduct/Harassment – Deputy 4 "stalked" Looney.

   Board Finding: Action Justified
   Rationale: Complainant Looney stated, "I believe Deputy [4] was stalking me that day and used his job as a deputy to cause me pain." The evidence showed Looney was identified as a suspect in felony crimes committed four nights prior and Deputy 4 was the responding deputy who took the crime report. The evidence showed that when Deputy 4 observed Looney on 02-11-24, he immediately recognized Looney as a felony wanted subject. Acting within his scope as a sworn peace officer, Deputy 4 coordinated the apprehension of Looney, in accordance with applicable laws and SDSO Policy and Procedures. By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

AYE: 5
ABSENT: 2
NAY: 0
ABSTAIN: 0

24-062/HARMON (Routine)

1. Misconduct/Procedure – Deputy 1 suspended Krista Harmon's visitation privileges on 04-14-24.

Board Finding: Action Justified
Rationale: Complainant Harmon reported she had a visit with an Incarcerated Person (IP) at San Diego Central Jail (SDCJ) when Deputy 1 ended the visit and asked for her contact information. Harmon also reported when she returned to the facility that day, Deputy 1 advised her visitation privileges were suspended for 30 days. According to SDSO documentation, Harmon was not allowed to conduct professional visits (provide notary services) at George Bailey Detention Facility (GBDF) from 04-15-24 to 06-15-24 due to a conflict of interest. Detention Services Bureau P&P, Section P.9 Social Visiting, subsection Visitation Suspension, states that social visits and video visitations are a privilege, and as such, may be suspended as part of a disciplinary action. In addition, at the discretion of the watch commander visitors may have their visit privileges suspended for any violation of the visit rules. Violations may result in an up to 60-day suspension of privileges. All suspensions shall be noted in JIMS. By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

2. Misconduct/Retaliation – Deputy 1 extended Krista Harmon's suspension due to a complaint.

Board Finding: Unfounded
Rationale: Complainant Harmon stated, "These unjustified actions at the hands of Deputy 1 can only be considered retaliation." Harmon reported her fiancée (IP in SDSO custody) submitted a CLERB complaint. Harmon said that after the CLERB complaint was submitted, her visitation privileges were suspended from 30 to 60 days. According to SDSO documentation, "Per Watch Commander, Harmon was not allowed to conduct professional visits at George Bailey Detention Facility (GBDF) from 04-15-24 to 06-15-24 due to conflict of interest." SDSO DSB P&P, Section P.9 Social Visiting, subsection Visitation Suspension, states that social visits and video visitations are a privilege, and as such, may be suspended as part of a disciplinary action. In addition, policy stated at the discretion of the watch commander visitors may have their visit privileges suspended for any violation of the visit rules. Violations may result in an up to 60-day suspension of privileges. All suspensions shall be noted in JIMS. By a preponderance of the evidence, CLERB determines the alleged act of retaliation did not occur.

AYE: 6
ABSENT: 1
NAY: 0
ABSTAIN: 0

24-069/COLES (Routine)

1. Misconduct/Procedure – Deputy 1 failed to arrest a person who assaulted Gyasi Coles.

Board Finding: Action Justified
Rationale: Complainant Gyasi Coles filed an incident report on 05-07-24 and stated he was the victim in a domestic violence incident that took place with his partner on 03-15-24. Coles complained that the assigned deputy failed to arrest his partner, although she allegedly threw lighter fluid on him and hit him on the head. Coles also reported he wished to press charges on his partner. On 05-07-24 and 05-08-24, Deputy 1 investigated the incident, interviewed the involved parties and obtained cell phone videos of the alleged incident. The deputy submitted the case to the District Attorney's (DAs) office for review. The DA rejected the case on 05-29-24 and the case was subsequently closed by SDSO. According to the SDSO Detectives Procedural Manual, D.2.2 Case Distribution and Processing, "Submitted DA" means no one has been arrested on the case. SDSO P&P Section 2.51, Arrest, Search and Seizure states employees shall not make any arrest nor conduct any investigation or official Department business, in a manner which they know or ought to know is not in accordance with law and established Departmental policies and procedures. By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

AYE: 6
ABSENT: 1
NAY: 0
ABSTAIN: 0

24-072/CHAMBERS (Routine)

1. Misconduct/Procedure – Deputy 2 failed to provide identifying information upon request.

Board Finding: Action Justified
Rationale: Complainant Parrish Chambers stated, "I asked the deputy to turn on the T.V. and he told me no. I asked him for his name and badge number, and he only gave his #." Per SDSO P&P Section 2.20 Identification deputies are not mandated to provide both their name and badge number, the policy states, "While on duty, all employees shall furnish their first and last name or ARJIS number to any person requesting his or her identity." Deputy 2 provided confidential information during CLERB's investigation that was considered in arriving at the recommended finding. By a preponderance of the evidence, CLERB determined the investigation proved the alleged actions were lawful, justified and proper.

2. Misconduct/Discourtesy – Deputy 2 told Chambers, "You're a fucken crybaby."

Board Finding: Not Sustained
Rationale: Complainant Chambers stated, "I asked the deputy again for his name and he stated, 'You're a fucken crybaby.'" Per SDSO P&P Section 2.22 Courtesy, 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. Deputy 2 provided confidential information during CLERB's investigation that was considered in arriving at the recommended finding. Absent audio evidence, CLERB determined the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

3. Misconduct/Discourtesy – Deputy 2 told Chambers to "shut the fuck up."

Board Finding: Not Sustained
Rationale: Complainant Chambers stated, "I asked the deputy for a grievance form and deputy 2 stated, 'Shut the fuck up.' My grievance was answered, and I kept reiterating it wasn't about the television it's about the disrespectful conduct that's been happening." Absent audio evidence, CLERB determined the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

4. Misconduct/Harassment – Deputy 1 harassed Chambers.

Board Finding: Not Sustained
Rationale: Complainant Chambers stated, "Approximately 20 minutes later, Deputy 1 came and started giving me a hard time about the T.V. and stating his badge number saying, 'write me up too, I'm with him,' repeating it escalating the situation as if to draw some sort of negative reaction from me." SDSO P&P Section 2.48 Treatment of Persons in Custody states, Employees shall not mistreat, nor abuse physically or verbally, persons who are in their custody. Employees shall handle such persons in accordance with law and established Office procedures. Deputy 1 provided confidential information during CLERB's investigation that was considered in arriving at the recommended finding. Absent audio evidence, CLERB determined the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

5. Misconduct/Procedure – Deputy 1 escorted Chambers to new housing.

Board Finding: Action Justified
Rationale: Complainant Chambers stated, "1 week after the 05-15-24 incident, 05-22-24, Deputy 1 ask, 'what's my affiliation?' because I was being moved out of medical housing. I let him know and he does the opposite, puts me in the wrong place and I feel it was done on purpose to either cause harm or inconvenience." SDSO DSB P&P Section I.51 Movement of Incarcerated Persons states, in part, "A rover deputy may be dispatched to escort the incarcerated person to their destination or holding area as expeditiously as possible (if escort is required). The rover will verify identifying information against the incarcerated person's wristband." Rover deputies play no part in the classification and assignment of new housing. Deputy 1 was the assigned Medical Rover Deputy and tasked with escorting Chambers to his new housing assignment. Deputy 1 provided confidential information during CLERB's investigation that was considered in arriving at the recommended finding. By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

AYE: 6

ABSENT: 1
NAY: 0
ABSTAIN: 0

24-084/WARE (Priority)

1. Excessive Force – Deputies 1-5 used force towards Victor Ware on 12-05-23.

   Board Finding: Action Justified
   Rationale: Complainant Ware reported while he was housed at George Bailey Detention Facility, deputies attempted to house a "mentally ill" person in the same cell as him. Ware stated he told deputies the two IPs were not compatible, but deputies punched him to the ground, sat on his back and tased him while he was in handcuffs. Ware reported he suffered scrapes, bruises, and a swollen nose as a result of the force used. SDSO Addendum F, Use of Force Guidelines states that deputies may only use a level of force they reasonably believe is proportional to the seriousness of the suspected offense or the reasonably perceived level of actual or threatened resistance. To be proportional, the level of force applied must reflect the totality of circumstances surrounding the situation at hand, including the nature and immediacy of any threats posed to officers and others. Deputies used physical control techniques, body strikes and a Conducted Energy Device (CED) to counteract Ware's assaultive behavior. By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

AYE: 6
ABSENT: 1
NAY: 0
ABSTAIN: 0

24-086/SHOEMAKER (Routine)

1. Misconduct/Procedure – Probation Officers 1 and 2 denied Morgan Shoemaker an Interstate Compact transfer.

   Board Finding: Summary Dismissal
   Rationale: Complainant Morgan Shoemaker alleged Probation Officers 1 and 2 denied her many requests for an Interstate Compact transfer to her home State of Tennessee. Shoemaker failed to provide the required documents that would authorize CLERB to obtain her adult probation records. Per CLERB Rules & Regulations Section 15 Summary Dismissal, after reviewing the Investigative Report and records, CLERB may summarily dismiss a Case, ("Summary Dismissal") upon recommendation of the Executive Officer, its own motion, or that of the Subject Officer. Parties to the complaint shall be notified of a proposed Summary Dismissal and may appear to argue for or against Summary Dismissal. Summary Dismissal may be appropriate in the following circumstances: Lack of cooperation by the complainant such that CLERB is unable to continue its investigation, such as a failure by the complainant to respond to repeated inquiries when such response is necessary to the ongoing investigation. As such, this case is submitted for Summary Dismissal.

AYE: 6
ABSENT: 1
NAY: 0
ABSTAIN: 0

24-101/CASTILLO (Routine)

1. Misconduct/Procedure – The San Diego Police Department arrested Christian Castillo on 04-18-24.

   Board Finding: Summary Dismissal
   Rationale: Complainant Castillo stated he was "falsely arrested" and the arrest caused him to fail his college semester. Castillo was arrested by the San Diego Police Department and booked into Sheriff's custody. According to CLERB Rules & Regulations, Section 4.1 Complaints: Authority, CLERB shall have authority to receive, review, investigate, and report on complaints filed against peace/custodial officers employed by the County in the Sheriff's Department. CLERB determines the investigation showed that CLERB lacks jurisdiction on the allegation.

2. Misconduct/Procedure – Deputy 1 "forced" Castillo to disclose information on 05-22-24.

   Board Finding: Action Justified
   Rationale: Complainant Castillo stated he was assaulted by other Incarcerated Persons (IPs) while incarcerated. The complainant also stated Deputy 1 then forced Castillo to disclose what occurred. SDSO DSB P&P, Section Q.51 Crimes Committed by "In Custody" Incarcerated Persons states whenever sufficient information becomes available to charge an incarcerated person with a crime, appropriate detention facility staff will complete appropriate reports. All assaults, whether prosecution is desired or not, will be documented in a crime report. The deputy wrote a crime report and body worn camera footage confirmed Deputy 1's interaction with Castillo complied with policy. By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

3. Misconduct/Procedure – Unidentified deputies failed to respond to Castillo's intercom communication.

   Board Finding: Not Sustained
   Rationale: Complainant Castillo stated deputies did not respond to his communication attempts through the intercom, but he did not disclose the reason(s) for his emergency communication. Castillo stated he documented the deputy names and badge numbers in several grievance forms. However, a request for these records were met with negative results. According to SDSO DSB, Section I.2 Intercom Systems, 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. At the beginning of each shift, sworn staff shall ensure intercoms have not been silenced or muted. Castillo was unable to provide any deputy names or dates for the alleged incidents for CLERB to investigate. 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 – Unidentified staff lost/misplaced Castillo's property.

   Board Finding: Unfounded
   Rationale: Complainant Castillo stated he was not provided his shoes, two hats, and a jacket upon release from custody on 07-17-24. Castillo also stated $100 worth of food and hygiene items "went missing and/or were stolen under the supervision of multiple deputies." SDSO DSB P&P, Section Q.7 Incarcerated Person Processing, states property accepted into custody with the incarcerated person will be inventoried and stored in a locked storage area for safekeeping. In addition, the Arresting Officer will itemize all personal items on the Booking Intake/Personal Property form. Castillo's property was documented at intake as a wallet, cell phone, keys and no shoes; there was no evidence that supported Castillo's statement of having shoes, hats or a jacket. SDSO DSB, Section Q.63 Lost Incarcerated Person Money or Property states when moving an incarcerated person to another housing unit, facility, or an incarcerated person is released, the deputy doing so shall ensure the person's module property is moved with the incarcerated person. When Castillo transferred to another facility, his intake property was transferred, but records showed there was no personal module property to transfer. Additionally, SDSO DSB Q.66, Transfer of Incarcerated Persons Property, states an IPs Property will remain in the garment bag and will be transferred intact. Castillo did not complete/submit a lost/stolen property form while he was in custody and stated he only received a t-shirt and pants upon release. Upon his release, Castillo signed an Inmate Personal Property Receipt accepting receipt of one sealed bag of clothes including documentation of "no shoes." By a preponderance of the evidence, CLERB determines the investigation disclosed sufficient evidence to prove the allegation did not occur.

AYE: 6
ABSENT: 1
NAY: 0
ABSTAIN: 0

24-108/GILLSON (GBI)

1. Use of Force Resulting in Great Bodily Injury – Deputy Derek Cockrum used force against Andrew Gillson on 06-26-24.

Board Finding: Sustained
Rationale: CLERB was notified on 08-02-24 of a San Diego Sheriff's Office (SDSO) use of force incident that resulted in an injury on 06-26-24. This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. Records related to the incident showed Deputy Cockrum ordered Gillson against a wall, and Gillson complied. A verbal exchange between Gillson and Deputy Cockrum was audibly and visually recorded. CCTV footage showed Deputy Cockrum shoving Gillson against a wall, causing Gillson to turn around into a bladed stance with his fist clenched. This was a result of Deputy Cockrum's physical escalation. Deputy Cockrum's written statement of events is inconsistent with BWC and CCTV footage reviewed. According to SDSO P&P Section 2.49, Use of Force, employees are instructed to only use the amount of force reasonably necessary in any situation, in compliance with the law and Office procedures, and to document all instances of force in writing. The investigation found sufficient evidence to support the allegation, as determined by a preponderance of the evidence.

2. Misconduct/Procedure – Deputy 1 failed to activate body worn camera in accordance with policy.

Board Finding: Sustained
Rationale: During the investigation, it was noted that BWC footage was unavailable for Deputy 1 and undocumented as required by policy. According to the San Diego Sheriff's Department Body Worn Camera Policy and Procedure 6.131, deputies shall activate their body-worn cameras (BWCs) whenever possible, prior to and during the entire duration of the following duties: escorting incarcerated individuals between areas, including cell movements, housing modules, holding cells, visitation, courts, intake, and final release. Review of CCTV footage revealed ample time for Deputy 1 to activate his BWC. Deputy 1 also provided information during CLERB's investigation that was used to help determine the recommended finding. By a preponderance of the evidence, the investigation determined there is evidence sufficient to prove the allegation.

AYE: 6
ABSENT: 1
NAY: 0
ABSTAIN: 0

24-119/BENEDICT (Priority)

1. Excessive Force – Deputy 1 used force against Richard Benedict.

Board Finding: Not Sustained
Rationale: The complainant, Richard Benedict, alleged that while housed at George Bailey Detention Facility (GBDF), a deputy used force against Benedict and "split open" Benedict's forehead. Evidence received from the San Diego Sheriff's Office (SDSO) showed on 07-20-24, Deputy 1 attempted to detain Benedict as Benedict had violated Incarcerated Person Rules and Regulations, pursuant to SDSO Detention Services Bureau P&P Section O.3. During the incident, Benedict resisted Deputy 1 by tensing up and attempting to pull away from Deputy 1. According to SDSO Use of Force guidelines, Deputy 1's report of his use of force was appropriate and proportional to Benedict's active resistant behavior. CCTV footage was received in this case. However, due to the distance of the camera from the incident, in addition to the poor video quality, no other distinguishable actions were noted. By a preponderance of the evidence, CLERB determines the investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

2. Misconduct/Procedure – Unidentified deputies placed Benedict in disciplinary separation.

Board Finding: Action Justified
Rationale: Benedict alleged he was subsequently placed in "solitary confinement," following the use of force incident. According to the evidence received from SDSO, Benedict was found to have violated rules and regulations of IPs and received 10 days disciplinary separation due to the violations. Pursuant to SDSO DSB P&P Section O.1, Disciplinary Action, Benedict's placement in disciplinary separation was within policy guidelines. By a preponderance of the evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

AYE: 3
ABSENT: 1

NAY: 0
ABSTAIN: 3

24-184/WARFIELD (Summary Dismissal)

1. Misconduct/Procedure – Deputy 1 failed to release property seized during the aggrieved's arrest.

   Board Finding: Summary Dismissal
   Rationale: Complainant Sharon Warfield alleged Deputy 1 failed to return property, belonging to the aggrieved that was seized during their arrest. The aggrieved's arrest was conducted by the San Diego Human Trafficking Task Force (SDHTTF) and the California Department of Justice (CAL-DOJ) was the responsible party on this case. As a member agency of the SDHTTF, SDSO assisted CAL-DOJ by towing the aggrieved's vehicle. The seized vehicle was searched by another Police Department with a search warrant and released to the aggrieved's family following the search. All other property was seized by a DOJ search warrant and turned over to the Investigator with the District Attorney's Office. CLERB Rules & Regulations 4.1 Complaints: Authority states pursuant to the Ordinance, CLERB shall have authority to receive, review, investigate, and report on complaints filed against peace officers or custodial officers employed by the County in the Sheriff's Office. Investigators with the District Attorney's office and CAL-DOJ employees do not fall within CLERB's purview to investigate. CLERB lacks jurisdiction. As such, this case is submitted for Summary Dismissal.

AYE: 6
ABSENT: 1
NAY: 0
ABSTAIN: 0

End of Report