County of San Diego

CITIZENS' LAW ENFORCEMENT REVIEW BOARD

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The Citizens' Law Enforcement Review Board made the following findings in the closed session portion of its **April 2, 2026**, 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 PERFORMANCE EVALUATION
Executive Officer: pursuant to Subdivision (b)(1) of Government Code Section 54957.
- After completing the personnel evaluation of the Executive Office, the board determined the Executive Officer was "Exceeding Expectations" and any salary modification should be retroactive to June 2025.

AYE: 10
ABSENT: 1
NAY: 0
ABSTAIN: 0

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

DEFINITION OF FINDINGS	
Action Justified	The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.
Not Sustained	There was 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 (10)

ALLEGATIONS, BOARD FINDINGS & RATIONALES

24-024/VILI (Death)

1. Death Investigation/In-custody Medical – Incarcerated Person (IP) Liutoa Vitale Vili died while incarcerated at the San Diego Central Jail (SDCJ) on 02-04-24.

   Board Finding: Adopted
   Conclusion: This case was reviewed in accordance with CLERB Rules and Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 06-26-23, Vili was arrested by Sheriff's deputies on three outstanding felony vandalism warrants. Vili was booked into jail and classified for placement in a medical dormitory due to mobility limitations requiring the use of a wheelchair. Due to documented instances of behavioral and mental health issues, including *"Lack of hygiene"* and "*Unpredictable behavior*", Vili was transferred to a Medical Isolation Cell (ISO). SDSO records indicated that safety checks and facility count procedures prior to the incident were documented in the Jail Information Management System (JIMS). Detention Services Bureau (DSB)

P&P Section I.64 Safety Checks states, *"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."* DSB P&P Section I.43 Count Procedures states, "*Count Procedures of Incarcerated Persons - All counts require sworn staff to verify each incarcerated person's well-being through 'verbal or physical acknowledgment' from the incarcerated person. In addition, sworn staff will look for any obvious signs of medical or physical distress (e.g., asthma attack, chest pain, etc.), trauma (e.g., bleeding, ligature marks, etc.) and/or criminal activity (e.g., drug usage, fighting, etc.). Incarcerated persons away from the facility for authorized reasons (e.g., court, medical appointments, etc.) will be accounted for upon their return."* Jail records reflected the safety checks were documented within the required time intervals and that IP Vili was accounted for during both "hard" and "soft" counts with no reported irregularities or signs of distress noted. The investigation was unable to independently corroborate the checks through closed-circuit television footage because the available video recordings did not capture the relevant housing area. On 02-04-24, during medication pass, attention was drawn to Vili when medical staff indicated that he had recently refused medication, which was described as atypical behavior. Vili was observed lying on his side inside the cell. When addressed, he moved slightly and responded with mumbled speech. Records reviewed during the investigation indicated that Vili had known mobility limitations and difficulty speaking clearly. Deputies and medical personnel discussed transporting Vili to the third-floor medical clinic for further evaluation. Records indicated IP Vili was conscious and breathing at that time. After completing the three remaining medication distributions in the housing unit, Deputy 1 returned to Vili's cell. Vili was described by Deputy 1 as sluggish but able to assist in transferring himself into a wheelchair. The time between the initial contact and removal from the cell and escort to medical was reported to be approximately five to ten minutes. While escorting Vili to the medical clinic, he began to slump forward in the wheelchair. Upon exiting the elevator on the medical floor, Vili appeared to lose consciousness. Deputies observed Vili was not breathing and initiated cardiopulmonary resuscitation. Chest compressions were started by deputies while medical personnel provided ventilation using an Ambu bag. Emergency medical services responded and transported Vili to a hospital for further treatment. Despite recusation efforts, Vili was pronounced deceased. The San Diego County Medical Examiner determined the cause of death to be cardiopulmonary arrest due to multifocal occlusive atherosclerotic coronary artery disease involving the left anterior descending and right coronary arteries. Contributing medical conditions included hypertension, unspecified cardiomyopathy, stage 3 chronic kidney disease, and gout. Pursuant to CLERB Rules and Regulations 16.1, upon conclusion of review by the full Board, CLERB shall deliberate and adopt a final report containing findings of fact and an overall conclusion as specified in 16.2.

2. Misconduct/Medical – Medical staff failed to comply with policy during medication distribution.

Board Finding: Summary Dismissal
Staff Recommended Finding: Summary Dismissal
Rationale: Medical records were reviewed as a part of the death investigation. The Treatment Administration Log contained multiple entries throughout Vili's incarceration documenting medications or wound-care treatments as *"Not Administered–Refused."* Specifically, entries dated 01-28-24, and 02-01-24 through 02-03-24, reflected multiple consecutive refusals in the "OTHER" medication/treatment category immediately preceding the 02-04-24 medical emergency. The format of the log identified the administering staff member, date, and time, followed by the notation *"Not Administered–Refused,"* without a narrative explanation in those entries as required by policy. The medical record did not reflect documentation of a completed medication refusal form (e.g., J-223) corresponding to those refusals, nor does it contain a documented referral to a physician, nurse practitioner, or psychiatrist specifically in response to the refusals as required by policy. Separate records showed that Vili continued to have scheduled medical and psychiatric appointments, including a psychiatry sick call on 02-03-24, during which medication, education, and adherence were discussed; however, this encounter was recorded as a routine follow-up rather than as a referral prompted by the documented refusals. Medical Services Division (MSD) P&P Section R.5, Refusal Procedures stated, "*Refusal 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. F. If medication is for TB or STDs, report to infection control nurse. G. The nurse should advise the patient that if he continues to*

refuse their medication after the above discussion, the order for their medication (except TB medications) may be rescinded/discontinued. Refer to MSDC for a case review if patient is chronically refusing recommended treatment. I. Instruct the patient to fill out a sick call request if they want to resume treatment." At the time of this incident, CLERB did not have jurisdiction over medical staff or contracted mental health providers for this in-custody death. The Review Board lacks jurisdiction.

3. Misconduct/Procedure – Deputy 1 failed to charge his Body Worn Camera (BWC).

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: The investigation determined that Deputy 1's BWC was not activated during this incident. Deputy 1 stated he had left his assigned BWC in his locker the previous night and that the battery was not charged. He further explained that he arrived late at work and immediately began escorting the nurse for medication pass. Deputy 1 indicated that he intended to obtain another BWC after completing the escort assignment. The available evidence reflected that Deputy 1 began his shift without ensuring that his assigned BWC was functioning and properly charged. Detention Services Bureau P&P Section I.20.II, Supplemental Guidelines for Detentions: *"Body Worn Cameras (BWC) – Beginning of shift BWC inspection – "A. Deputies assigned a BWC will be responsible at the beginning of each shift for ensuring the BWC is functioning properly, and the battery is properly charged. B. Should adjustment or repair be needed to the BWC, the deputy will notify facility administrative staff through email and will include their immediate supervisor. C. The deputy's immediate supervisor should ensure a "pool" camera is properly enrolled for the deputy to utilize until the adjustment or repairs to the deputy's original BWC completed, or until the deputy has a permanent replacement. D. The facility/unit administrative staff will promptly notify the appropriate data services/maintenance/facilities staff to schedule the adjustment, repair, or replacement."* The investigation disclosed evidence sufficient to prove the allegation by a Preponderance of the Evidence.

AYE: 10
ABSENT: 1
NAY: 0
ABSTAIN: 0

24-194/PATTON (Death)

1. Death Investigation/In-custody Medical – Incarcerated Person (IP) Bobby Ray Patton Jr. died while incarcerated at the Vista Detention Facility (VDF) on 12-28-24.

   Board Finding: Adopted
   Conclusion: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. Booking and medical records indicated that IP Patton was arrested by Riverside County Sheriff's deputies on a San Diego County felony probation violation warrant and transferred to the custody of SDSO on 11-25-24, where he was booked into the Vista Detention Facility (VDF). IP Patton was evaluated by the Jail Population Management Unit (JPMU) for classification and housing and designated as a Level 3 IP. During intake medical screening, Patton reported a history of fentanyl use and participation in a methadone treatment program through the Substance Use Overdose/Addiction Program–Medication Assisted Treatment (SOAP-MAT) clinic. A urine drug screen returned positive for methadone and fentanyl. Medical staff initiated detox monitoring and ordered medications commonly used to address withdrawal symptoms. Medical records dated 11-28-24 reflected that detox monitoring was discontinued after staff documented stable vital signs and improved withdrawal scores. Subsequent medical records recorded on 12-24-24, Patton reported flu-like symptoms and was evaluated at the clinic. Then on 12-27-24, Patton reported chest pain and shortness of breath and was again evaluated by medical staff. A chest X-ray later documented abnormal substances/fluids, and antibiotics were prescribed for suspected pneumonia. Later that evening, around 9:45pm on 12-27-24, Patton activated the intercom from his cell, reporting severe chest pain and difficulty breathing. Deputies responded and escorted Patton to the clinic for medical evaluation. BWC footage and reports documented that Deputy 3 was involved in escorting Patton to the clinic for this evaluation. Medical documentation indicated that after the evaluation, Patton was returned to housing. Area activity reports and CCTV footage reflected that safety checks were conducted timely within the housing module until approximately 6:00am. Deputy 3 began a safety check at approximately 6:00am. (See Rationales 2, 3 & 4). At approximately 6:55am, Deputy 1 conducted a safety check and briefly looking into Patton's cell while audible moaning was heard. The footage

showed Deputy 1 continued with the safety check of the module. (See Rationales 5 & 6). At approximately 7:51am, another deputy conducted a safety check and BWC footage showed Patton lying on the lower bunk making groaning sounds while moving his feet. That deputy finished the safety check and at 8:05am, returned to Patton's cell, opened the door, and interacted with Patton before leaving the module and returning at approximately 8:13am, with members of the MAT team. Around 8:15am, deputies and RN Munoz-Rodriguez arrived at Patton's cell. BWC footage showed Patton seated on the floor while Deputy 2 attempted to obtain vital signs. (See Rationale 7). During the interaction, Patton became unresponsive. A nurse assessed for a pulse and initiated CPR when she did not detect one. Deputies administered Narcan and provided rescue breaths. Additional medical staff arrived and continued resuscitative efforts, including application of an Automated External Defibrillator (AED). Vista Fire Department paramedics arrived at approximately 8:31am and assumed medical care. Patton was pronounced deceased at approximately 8:45am. Per the Medical Examiner's Autopsy Report dated 02-28-25, *"…based on these findings and the history and circumstances of the death, as currently known, the cause of death is certified as acute bacterial bronchopneumonia complicating Influenza A infection. Substance use disorder and effects of methadone are listed as contributing. The manner of death is accident."* SDSO Detention Services Bureau (DSB) Policy & Procedure Section I.64, Safety Checks 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."* Section M.5, Medical Emergencies stated, *"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."* Pursuant to CLERB Rules and Regulations 16.1, at the conclusion of a matter before the entire CLERB, the Board shall deliberate and adopt a final report with findings of fact and an overall conclusion as specified in Section 16.2.

2. Misconduct/Procedure – Deputy 3 failed to recognize or respond to a medical emergency during a safety check on 12-28-24.

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: SDSO records confirmed on 12-27-24 around 9:45pm, IP Patton activated the intercom from his housing cell and reported severe chest pain and difficulty breathing. Deputies, including Deputy 3, escorted Patton to the clinic for evaluation by medical staff. On 12-28-24, at approximately 6:02am, Deputy 3, while wearing BWC, conducted a safety check. As Deputy 3 approached IP Patton's cell, audible moaning was captured on the recording, along with Patton saying, *"I can't breathe,"* and *"I'm having chest pain so bad."* Deputy 3 looked through the cell door window while Patton continued audibly moaning. Deputy 3 then turned away from the cell and continued toward the exit of the module. As Deputy 3 walked away from the cell door, Patton said, "*Please help me."* Deputy 3 exited the module shortly thereafter and turned off their BWC. DSB P&P Section M.5, Medical Emergencies stated, *"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."* SDSO P&P Section 2.4, Unbecoming Conduct stated, "*Employees shall conduct themselves at all times, both on and off duty, in such a manner as to reflect most favorably on this Office. Unbecoming conduct shall include that which tends to bring this Office into disrepute or reflects discredit upon the employee as a member of this Office, or that which tends to impair the operation and efficiency of this Office or employee*." SDSO P&P Section 2.30, Failure to Meet Standards stated, "*Employees shall properly perform their duties and assume the responsibilities of their positions. Employees shall perform their duties in a manner which will tend to establish and maintain the highest standards of efficiency in carrying out the mission, functions, and objectives of this Office. Failure to meet standards may be demonstrated by a lack of knowledge of the application of laws required to be enforced; an unwillingness or inability to perform assigned tasks; the failure to conform to work standards established for the employee's position; the failure to take appropriate action on the occasion of a crime, disorder, or other condition deserving police attention; absence without leave; unauthorized absence from the assignment during a tour of duty; the failure to submit complete and accurate reports on a timely basis when required or when directed by a supervisor*." Deputy 3 provided a confidential statement to CLERB that was considered as a part of the investigation. SDSO also provided confidential personnel records to CLERB that were considered as part of the investigation. The investigation disclosed evidence sufficient to prove the allegation by a Preponderance of the

Evidence. Per CLERB Rules and Regulations Section 16.3, Consideration of Subject of Investigation's Disciplinary History, "*Only after a finding of "Sustained" with respect to an allegation of improper or illegal conduct by a Subject of Investigation should CLERB consider … the appropriate recommendation for discipline."*

3. Criminal Conduct – Deputy 3 was negligent in their duties on 12-28-24.

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: See Rationales 1 & 2. Per Penal Code, Section 20 and defined by People v. Penny (1955) 44 Cal.2d 861, 879 [285 P.2d 926] and People v. Rodriguez (1960) 186 Cal.App.2d 433, 440 [8 Cal.Rptr. 863], *a person acts with criminal negligence when: "He or she acts in a reckless way that creates a high risk of death or great bodily injury; and a reasonable person would have known that acting in that way would create such a risk.*" It should be noted the burden of proof for CLERB is preponderance of the evidence whereas for a criminal offense (i.e. CA Penal Code Section 192(b)) the burden of proof is beyond a reasonable doubt.) Deputy 3 provided a confidential statement to CLERB, which was reviewed and considered as part of this investigation. SDSO also provided confidential personnel records to CLERB that were considered as part of the investigation. The investigation disclosed evidence sufficient to prove the allegation by a Preponderance of the Evidence.

4. Misconduct/Procedure – Deputy 3 failed to complete a safety check on 12-28-24.

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: See Rationales 1, 2 & 3. On 12-28-24, at approximately 6:02am, Deputy 3, while wearing BWC, conducted a safety check. After stopping at IP Patton's cell, Deputy 3 exited the lower level of the housing unit without proceeding to the upper tier. Deputy 3 exited the module shortly thereafter and turned off their BWC. There was no evidence documented of why the safety check was not completed. DSB P&P Section I.64, Safety Checks 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.* Deputy 3 provided a confidential statement to CLERB that was considered as a part of the investigation. SDSO also provided confidential personnel records to CLERB that were considered as part of the investigation. The investigation disclosed evidence sufficient to prove the allegation by a Preponderance of the Evidence.

5. Misconduct/Procedure – Deputy 1 failed to recognize or respond a medical emergency during a safety check on 12-28-24.

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: See Rationale 1. CCTV and BWC footage showed that at approximately 6:55am, Deputy 1 entered the housing module to conduct a safety check. The footage showed Deputy 1 interacting with an incarcerated person in a neighboring cell while conducting the safety check. As Deputy 1 approached cell 6, occupied by IP Patton, audible moaning was captured on the recording. The footage showed Deputy 1 stopping briefly at the cell door and looking into the cell before continuing the safety check and proceeding to the upper tier of the module. The audio captured Patton audibly moaning and making statements that were largely unintelligible, with portions of a statement appearing to reference difficulty breathing. It was unclear from the evidence reviewed whether Deputy 1 was aware of Patton's specific statements, as she was simultaneously interacting with an incarcerated person in a neighboring cell at the time the statements were made. DSB P&P Section I.64, Safety Checks 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."* Deputy 1 provided a confidential statement that was considered as a part of this investigation. SDSO provided confidential personnel records to CLERB that were considered as part of the investigation. The investigation disclosed evidence sufficient to prove the allegation by a Preponderance of the Evidence.

6. Misconduct/Procedure – Deputy 1 failed to conduct Count Procedures per policy on 12-28-24.

Board Finding: Sustained
Staff Recommended Finding: Sustained
Rationale: See Rationales 1 & 5. On 12-28-24, at approximately 6:02am, Deputy 1, while wearing BWC, conducted a safety check. DSB P&P Section I.43, Count Procedures of Incarcerated Persons stated, *"All counts require sworn staff to verify each incarcerated person's well-being through "verbal or physical acknowledgment" from the incarcerated person. In addition, sworn staff will look for any obvious signs of medical or physical distress (e.g., asthma attack, chest pain, etc.), trauma (e.g., bleeding, ligature marks, etc.) and/or criminal activity (e.g., drug usage, fighting, etc.)...* Deputy 1 provided a confidential statement that was considered as a part of this investigation. SDSO also provided confidential personnel records to CLERB that were considered as part of the investigation. The investigation disclosed evidence sufficient to prove the allegation by a Preponderance of the Evidence.

7. Criminal Conduct – Deputy 1 was negligent in their duties on 12-28-24.

Board Finding: Sustained
Staff Recommended Finding: Sustained
Rationale: See Rationales 5 & 6 of Investigative Report. Per Penal Code, Section 20 and defined by People v. Penny (1955) 44 Cal.2d 861, 879 [285 P.2d 926] and People v. Rodriguez (1960) 186 Cal.App.2d 433, 440 [8 Cal.Rptr. 863], *a person acts with criminal negligence when: "He or she acts in a reckless way that creates a high risk of death or great bodily injury; and a reasonable person would have known that acting in that way would create such a risk.*" It should be noted the burden of proof for CLERB is preponderance of the evidence whereas for a criminal offense (i.e. CA Penal Code Section 192(b)) the burden of proof is beyond a reasonable doubt. Deputy 1 provided a confidential statement to CLERB, which was reviewed and considered as part of this investigation. SDSO also provided confidential personnel records to CLERB that were considered as part of the investigation. The investigation disclosed evidence sufficient to prove the allegation by a Preponderance of the Evidence.

8. Misconduct/Procedure – Deputy 2 failed to defer to on-scene medical staff during a medical emergency.

Board Finding: Not Sustained
Staff Recommended Finding: Not Sustained
Rationale: See Rationale 1. At approximately 7:51am, a deputy conducted a safety check and BWC footage showed IP Patton lying on the lower bunk making groaning sounds while moving his feet. The deputy finished the safety check and at 8:05am, returned to Patton's cell, opened the door, and interacted with Patton before leaving the module and returning at approximately 8:13am, with members of the MAT team. At approximately 8:15am, Deputies along with a nurse, responded to IP Patton's cell. Deputy 2 entered the cell and placed a blood pressure cuff on Patton's arm and a pulse oximeter on his finger to obtain the IP's vital signs but was unsuccessful. A nurse was present outside the cell and BWC confirmed the nurse entered the cell at 8:20am and personally attempted to gather a vital sign by manually by applying fingers to IP Patton's carotid vein. At 8:21am, the nurse initiated CPR by providing chest compressions and Deputy 2 provided rescue breaths. Deputy 2 provided a confidential statement to CLERB that was considered as a part of the investigation. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

AYE: 10
ABSENT: 1
NAY: 0
ABSTAIN: 0

25-032/DANIELS (Routine)

1. Misconduct/Procedure - Deputy 1 failed to provide Ione Daniels with his identification.

Board Finding: Action Justified
Staff Recommended Finding: Action Justified
Rationale: Complainant Ione Daniels alleged Deputy 1 did not provide his identification when requested. Body Worn Camera (BWC) footage showed, while Deputy 1 was interviewing the owner of a residence, Daniels approached the entry of the residence and requested Deputy 1's name and identification number. Deputy 1

directed Daniels to step away from the residence and stated he would provide the information to her. Deputy 1 repeatedly told Daniels to step away and that he would provide his information. Daniels continued arguing with Deputy 1 and would not follow Deputy 1's instructions. Deputy 1 then approached Daniels' son and stated, *"…If you want to ask me, I'll give you my information… because you seem calmer… and you want to talk with me."* Daniels' son responded, *"I'm not really calm right now."* Ione Daniels continued arguing from the front porch of the residence. Deputy 1 stated he was leaving and advised the Danielses that if they did anything to the owner's residence or property, Deputy 1 would arrest them for vandalism. Sheriff's Policy 2.20, Identification, stated, "*Sworn employees shall carry their identification cards on their persons at all times, except when impractical or dangerous to their safety or to an investigation. While on duty, all employees shall furnish their first and last name or ARJIS number to any person requesting his or her identity, except when the withholding of such information is necessary for the performance of police duties.*" The investigation showed the alleged act did occur but was lawful, justified, and proper.

2. False Arrest – Deputies 1, 2, and 3 arrested Ione Daniels on 03-03-25.

   Board Finding: Action Justified
   Staff Recommended Finding: Action Justified
   Rationale: Complainant Ione Daniels alleged she was falsely arrested. Deputy reports, BWC, and dispatch records were reviewed. The evidence showed, on 03-03-25, deputies responded to a residence after the homeowner reported that Daniels had entered his home without permission and refused to leave when asked. Deputies 1 and 2 arrived and were informed by the homeowner that Daniels was inside a locked bedroom within the residence. Deputies approached the bedroom door, identified themselves, and instructed Daniels to unlock the door and exit the room. Daniels initially refused and stated she would wait until her son arrived. Deputies informed her the interaction was being recorded on BWC and continued instructing her to exit. Additionally, Deputies advised Daniels that she was trespassing and had to leave the house. After several minutes, Daniels opened the door. Deputies instructed Daniels to leave the residence; however, she did not comply. Deputy 1 attempted to detain Daniels by placing handcuffs on her wrists. (See Rationale 3.) Daniels was charged with violation of PC Section 148, PC 148 (A)(1) Obstruct/Resist a Peace Officer and Section 602 (O)(2) Trespass: Refuse To Leave Property: Owner Request, and was subsequently booked into custody. 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."* The investigation showed the alleged act did occur but was lawful, justified, and proper.

3. Excessive Force – Deputies 1, 2, and 3 used force to arrest Ione Daniels on 03-03-25.

   Board Finding: Action Justified
   Staff Recommended Finding: Action Justified
   Rationale: Complainant Ione Daniels alleged that deputies used excessive force during her arrest on 03-03-25. (See Rationale 2.) Daniels stated that deputies *"jumped on top of"* her when she opened the door, pulled her hair, and caused her clothing to be pulled down while detaining her. Deputies instructed Daniels to leave the residence; however, she did not comply. Deputy 1 attempted to detain Daniels by placing handcuffs on her wrists. BWC footage showed Daniels resist by pulling away from Deputy 1 as he attempted to secure the handcuffs. Deputy 1 then grabbed Daniels' jacket and brought her to the floor. Daniels landed on her side and rolled onto her back while clasping her hands together. Deputies 1 and 2 attempted to roll Daniels onto her stomach to secure her arms for handcuffing. Daniels continued to resist by keeping her arms underneath her body. Deputies were eventually able to secure both wrists in handcuffs. Deputies escorted Daniels toward a patrol vehicle; however, Daniels continued to resist by kicking, screaming, and refusing to walk willingly. At the patrol vehicle, Daniels further resisted by bracing her feet and extending her legs. During this process, Daniels slipped one hand out of the handcuffs. Deputy 1 regained control of Daniels' arm and reapplied the handcuffs. Deputies requested medical personnel to evaluate Daniels; she declined medical evaluation. SDSO P&P Section 2.49, Use of Force, stated, *"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."* The investigation showed the alleged act did occur but was lawful, justified, and proper.

4. Misconduct/Procedure - Deputy 1 failed to provide (eviction) "service" to Ione Daniels.

Board Finding: Action Justified
Staff Recommended Finding: Action Justified
Rationale: Complainant Ione Daniels alleged she was not properly served an "*eviction*" notice. (See Rationales 2 and 3.) Deputies were dispatched to a report of Daniels trespassing at a residence. There was no evidence deputies were at the property to serve an eviction notice on Daniels. Daniels was charged with Obstruct/Resist a Peace Officer and Trespass: Refuse To Leave Property: Owner Request, and was subsequently booked into custody. The investigation showed the alleged act did occur but was lawful, justified, and proper.

AYE: 10
ABSENT: 1
NAY: 0
ABSTAIN: 0

25-044/WERKER (Routine)

1. Misconduct/Procedure - Unidentified deputies evicted Herbert Werker and served him with a TRO (Temporary Restraining Order) on 09-23-20.

   Board Finding: Summary Dismissal
   Staff Recommended Finding: Summary Dismissal
   Rationale: Complainant Herbert Werker provided TRO documents dated 09-23-20. Werker was listed as the "restrained person." The individual "protected" was a relative of his former employer. The judge granted a "Stay Away Order," requiring Werker stay 100 yards away from the relative and their home. The judge authorized a "Move Out Order" and "ordered" the SDSO to "remove" Werker. The investigation showed the TRO was lawful, justified, and proper, however CLERB lacks jurisdiction because the complaint was not timely filed. The Review Board lacks jurisdiction.

2. Misconduct/Procedure – Unidentified deputies failed to take a report on 9-23-20.

   Board Finding: Summary Dismissal
   Staff Recommended Finding: Summary Dismissal
   Rationale: Complainant Werker alleged on 09-23-20, after deputies served Werker with a TRO, they failed to take a report for threats Werker perceived to have received from his former employer. Per CLERB R&R Section 4 Authority, Jurisdiction, Duties and Responsibilities of CLERB. 4.1.2 Complaints: Jurisdiction…. CLERB shall not have jurisdiction to take any action in respect to complaints received more than one year after the date of the incident giving rise to the complaint… Per CLERB R&R Section 15, Summary Dismissal: CLERB does not have jurisdiction because the complaint was not timely filed. The Review Board lacks jurisdiction or the allegation clearly lacks merit.

3. Misconduct/Procedure - SDSO Records Division failed to forward a crime report to the courthouse on 10-11-24.

   Board Finding: Summary Dismissal
   Staff Recommended Finding: Summary Dismissal
   Rationale: Complainant Werker was involved in civil litigation with his former employer. On 10-11-24 Werker submitted an electronic request to SDSO Records Division for records to be sent directly to the court. Werker received an automated response that he interpreted to mean the request would be granted. Per Werker's complaint, he called SDSO Records Division, "…I called 3 times the record system and I was told that a delivery unit will send the police report from April accordingly on time to Department 31…" CLERB lacks jurisdiction with personnel in the SDSO Records Division who are non-sworn personnel. Per CLERB R&R Section 4, Authority: 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 Department or the Probation Department…The Review Board lacks jurisdiction.

4. Misconduct/Procedure – Deputy 1 failed to investigate criminal threats on 01-02-25.

   Board Finding: Action Justified
   Staff Recommended Finding: Action Justified
   Rationale: Complainant Werker alleged Deputy 1 failed to investigate a crime and forward the investigation to the District Attorney's Office. Werker filed a report with SDSO on 04-17-24 alleging he was threatened by his former

employer in 2020, and the former employer "falsely evicted" Werker and "wrongfully" filed a temporary restraining order against Werker on 09-23-20. Deputy 1 was assigned the case to investigate. Werker's statement to the reporting deputy, Deputy 1, and CLERB indicated Werker interpreted a comment made by his former employer as a threat, however, Werker did not articulate language or actions to indicate specific intent, a required element of the crime for California Penal Code 422 (a) Criminal Threats. 422(a) PC states, "*Any person who willfully threatens to commit a crime which will result in death or great bodily injury to another person, with the specific intent that the statement…is to be taken as a threat…which on its face and under the circumstances in which it is made, is so unequivocal, unconditional, immediate, and specific as to convey to the person threatened, a gravity of purpose and an immediate prospect of execution of the threat, and thereby causes that person reasonably to be in sustained fear for their own safety or for their immediate family's safety shall be punished*…" Werker admitted to Deputy 1, that after the comment, no other words or actions were taken to satisfy the criminal element of "*a gravity of purpose and an immediate prospect of execution of the threat*." The investigation showed the alleged act did occur but was lawful, justified, and proper.

5. Misconduct/Procedure – Deputy 1 did not investigate a "murder plot" reported on 01-02-25.

   Board Finding: Action Justified
   Staff Recommended Finding: Action Justified
   Rationale: Herbert Werker alleged he reported "a murder plot" to Deputy 1 on 01-02-25. Per the email Werker sent to Deputy 1, his former employer *"… was still in possession of weapons and that his (redacted) and my client of Live-In Care taking was already dead, burned to ashes and transported out of the country, raised my concern of foul play…"* Per correspondence with the San Diego County Medical Examiner's Office, the individual Werker was concerned about, died of natural causes. The investigation showed the alleged act did occur but was lawful, justified, and proper.

AYE: 10
ABSENT: 1
NAY: 0
ABSTAIN: 0

25-059/FLYNN (GBI)

1. Use of Force Resulting in Great Bodily Injury – Deputies Darren Abrams, Nelson Aguirre, Raymond Altmeyer, Joseph Kabandauli, and Ahmed Yammout used force on Incarcerated Person (IP) Kerry Flynn resulting in injury on 04-01-25.

   Board Finding: Action Justified
   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 04-01-25, IP Flynn was in custody at San Diego Central Jail (SDCJ) and housed in the Psychiatric Stabilization Unit (PSU). Flynn was the subject of a valid court order medication mandate. IP Flynn refused to comply with the court order and told a Lieutenant, "*I'm going to gouge your fucking eyes out…I'm going to come back here with my gun, I'm going to stalk you and [redacted] to where you live, and then I'm going to fucking pop you, you fucking pig".* Flynn had smeared feces on his cell window, along his cell walls, and threatened to throw feces at medical staff and deputies if they attempted to administer medication. A Tactical Response Team was utilized to forcefully remove IP Flynn from his cell. When deputies entered the cell, IP Flynn ran toward the back of the cell. Deputy Aguirre activated and pressed his Electronic Immobilization Shield against IP Flynn's back and used it to pin him against the cell wall. IP Flynn resisted deputies attempts to restrain him by tucking his arms between his body and the cell wall. Deputies were able to force IP Flynn to the ground where he landed in a seated position. IP Flynn continued to resist deputies by refusing to obey verbal commands, flailing his arms and legs, and grabbing their arms. IP Flynn grabbed onto Deputy Abram's arm and pulled it into his body. Deputy Abrams issued verbal commands for IP Flynn to let go of his arm, however, IP Flynn refused. Deputy Abrams used a closed fist to strike IP Flynn's right forearm one time. The force was not effective, and IP Flynn refused to let go of Deputy Abrams arm. Deputy Abrams forcefully pulled his arm out from IP Flynn's grip and gained control of IP Flynn's left arm. Deputies were able to secure IP Flynn into handcuffs and ankle restraints. IP Flynn was lifted onto a medical gurney and removed from the cell where a nurse administered IP Flynn's medication via injection. IP Flynn sustained an injury during the cell extraction and was medically evaluated by nursing staff. During the medical evaluation, IP Flynn continued to be belligerent and

spat at a deputy which resulted in spit restraint device being placed over IP Flynn's face. Contracted medical doctors determined IP Flynn needed further medical treatment. San Diego Fire Department and Paramedics responded to SDCJ and transported IP Flynn to the hospital for further treatment. SDSO P&P Section 11.9, Types of resistance: *Passive Noncompliance: is represented by not responding to verbal commands but also offers no physical form of resistance. Active Resistance: refers to physically evasive movements to defeat a deputy's attempt at control, including bracing, tensing, running away, or verbally or physically signaling an intention to avoid or prevent being taken into or retained in custody. Assaultive Behavior: is represented by aggressive or combative behavior, attempting to assault the deputy or another person, or verbally or physically displaying an intention to assault the deputy or another person. Life-Threatening Behavior: refers to any action likely to result in serious bodily injury to or death of the deputy or another person (other than the subject).* SDSO P&P Section 1.18, Conducted Energy Devices, Electronic Immobilization Shield: *Electronic Immobilization Shield is a poly-carbonate shield equipped with conductive strips that deliver electrical impulses. The shield is generally used to repel or temporarily incapacitate subjects during cell extractions, riots, or crowd control.* Section M.24, Involuntary Medication: *A. Medications administered on an involuntary basis must be prescribed by a physician. B. Prior to the administration of involuntary medications, individuals shall be given the opportunity to take the prescribed medications compliantly. B.2. If an individual refuses to take the medication: a. the watch commander shall be notified. All non-compliant involuntary medication administrations shall be performed under the direct supervision of the watch commander or designee; b. Health staff shall prepare the medication in a syringe with a needle-based safety device or retractable needle; c. Deputies may use appropriate measures to restrain the individual during health staff's administration of the medication, consistent with Addendum F and SDSD P&P section 6.48.* By preponderance of evidence, CLERB determines the investigation proved the alleged actions were lawful, justified and proper.

AYE: 10
ABSENT: 1
NAY: 0
ABSTAIN: 0

25-104/CAUL (Routine)

1. Misconduct/Medical – Medical staff withheld medication from IP Caul.

   Board Finding: Summary Dismissal
   Staff Recommended Finding: Summary Dismissal
   Rationale: Christopher Caul alleged medical staff withheld certain medication from Caul while incarcerated. Of the two medications claimed to have been withheld, one was provided to Caul and the other was refused four times by Caul. Pursuant to CLERB Rules and Regulations, Section 15, Summary Dismissal, CLERB does not have jurisdiction over the subject matter of the allegation.

2. Misconduct/Procedure – Unidentified staff were *"trying to get me* (IP Caul) *to kill myself or to get killed in prison*"

   Board Finding: Unfounded
   Staff Recommended Finding: Unfounded
   Rationale: IP Caul alleged staff were, "*trying to get me to kill myself or to get killed in prison*." A review of Caul's booking file revealed he was appropriately placed into Enhanced Observation Housing (EOH) at Intake and placed into housing after a subsequent mental health evaluation. Incident Reports were written by sworn staff documenting his placement into Enhanced Observation Housing and his subsequent move to a housing module. A review of Body Worn Camera revealed IP Caul was treated respectfully during interactions with staff. IP Caul was in SDSO custody from 07-12-25 to 07-17-25. The investigation clearly established that the allegation is not true.

AYE: 10
ABSENT: 1
NAY: 0
ABSTAIN: 0

25-115/MINEO (Routine)

1. False Arrest – Unidentified deputies detained and arrested Kendall Mineo for trespassing.

Board Finding: Summary Dismissal
Staff Recommended Finding: Summary Dismissal
Rationale: Complainant Mineo alleged unidentified deputies falsely detained and arrested him for trespassing on his own property. Mineo has failed to respond to multiple requests for additional information required to investigate the complaint. Pursuant to CLERB Rules and Regulations, Section 15, Summary Dismissal, CLERB investigators determined the 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.

2. Illegal Search or Seizure – Unidentified deputies impounded Mineo's motorcycle.

Board Finding: Summary Dismissal
Staff Recommended Finding: Summary Dismissal
Rationale: Complainant Mineo alleged deputies illegally impounded his motorcycle. Mineo has failed to respond to multiple requests for additional information required to investigate the complaint. Pursuant to CLERB Rules and Regulations, Section 15, Summary Dismissal, CLERB investigators determined the 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.

AYE: 10
ABSENT: 1
NAY: 0
ABSTAIN: 0

25-124/RICHARDSON (Routine)

1. Illegal Search or Seizure – Deputy 5 detained Tracy Richardson on 04-10-25.

Board Finding: Action Justified
Staff Recommended Finding: Action Justified
Rationale: Complainant Richardson alleged Deputy 5 illegally detained him when "*it was a he-said/she-said situation with no reasonable articulable suspicion or probable cause to justify detention".* Deputies responded to a radio call regarding a battery that occurred at a protest. The details and description provided to 911 operators stated a male matching Richardson's description was at the location counter-protesting and had been involved in a physical altercation. While deputies were conducting their investigation, Richardson asked if he was detained. Deputy 2 initially stated Richardson was not detained; however, Deputy 5, the Field Training Officer, verbally informed Richardson that he was detained while they conducted their investigation into a potential battery. Richardson was not placed into handcuffs; the detention was verbal only. After deputies determined Richardson was not a suspect, he was verbally advised that he was no longer detained. California Commission on Peace Officers Standards and Training LD 15 Version 4.17- Section 3- Detentions: defines Reasonable Suspicion as the standard used to justify detention. "*It exists when an officer has sufficient facts and information to make it reasonable to suspect that criminal activity may be occurring and the person to be detained is connected to that activity. Reasonable suspicion may be based on observation, personal training and experience, or information from eyewitnesses, victims, or other officers (totality of the circumstances)".* SDSO P&P Section 2.51- Arrest, Search and Seizure: "*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."* The investigation showed the alleged act did occur but was lawful, justified, and proper.

2. Misconduct/Discourtesy – Deputy 1 was discourteous towards Richardson on 04-10-25.

Board Finding: Unfounded
Staff Recommended Finding: Unfounded
Rationale: Complainant Richardson alleged that on 04-10-25, Deputy 1 *"displayed unprofessional and belittling behavior. He made dismissive comments and misrepresented my actions"*. See Rational 1. During the investigation, Richardson made multiple efforts to approach another involved party while recording with his cellphone. A review of the BWC footage showed Deputy 1 repeatedly asking Richardson to keep his distance and to stop attempting to interact with the other party. A review of BWC footage showed Deputy 1 maintained

professionalism throughout the interaction with Richardson. Deputy 1 verbally relayed to Richardson his perception of Richardson's actions which Richardson did not agree with. Sheriff's P&P 2.22 Courtesy states: "*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."* The investigation clearly established that the allegation is not true.

3. Misconduct/Procedure - Deputies 2, 3, 4 and 5 muted their BWC's and did not provide written documentation.

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: See Rational 1. On 04-10-25, Deputies muted their BWC's for approximately 2 minutes each while they conferred with one another. The deputies did not engage with any external parties involved in the investigation while their BWC's were muted. The reason for muting their BWC's was permitted under SDSO's current BWC policy, however, the muting was not documented in writing as required. Confidential statements were considered in this investigation. SDSO P&P Section 6.131, Muting: "*BWC's are equipped with functionality to allow for the "muting" of the camera. This allows video recording without audio. Muting is generally discouraged; however, there are situations in which muting may be beneficial. The muting of the camera shall only be performed as directed by a supervisor or in accordance with the specific considerations of this policy. Audio may be muted for a specific articulable reason and only for the amount of time necessary to complete the privileged conversation. Once privileged conversation has concluded, the camera shall be returned to full function. In all instances of muted audio, the deputy will document the reason for muting. Before muting the recorder, the deputy shall consider verbally explaining the reason for muting. Here are considerations for muting: TACTICAL CONSIDERATIONS. In all cases where BWC video is muted, it shall be documented in writing. How it is documented will be situationally dependent. The reason for muting the camera(s) will be briefly noted in the body of a report (arrest, crime misc. incident). In the case of confidential information, a separate supplemental report shall be written as detailed above. Additionally, a brief explanation noting the muting of the camera(s) will be documented via CAD by each deputy that muted their camera. If no report for an event is otherwise needed, CAD documentation shall suffice".* The investigation disclosed evidence sufficient to prove the allegation by a Preponderance of the Evidence.

AYE: 6
ABSENT: 1
NAY: 3
ABSTAIN: 1

4. Misconduct/Procedure - The District Attorney's Office failed to notify Richardson of his case disposition.

   Board Finding: Summary Dismissal
   Staff Recommended Finding: Summary Dismissal
   Rationale: Complainant Richardson alleged the District Attorney's Office did not notify him of the case disposition which he believed was a violation of Marsy's Law- California Constitution Article I, 28 section (b)(6): *Reasonable notice of and to reasonably confer with the prosecuting agency, upon request, regarding, the arrest of the defendant if known by the prosecutor, the charges filed, the determination whether to extradite the defendant, and, upon request, to be notified of and informed before any pretrial disposition of the case.* Deputies are not bound by this subsection of Marsy's Law as it only relates to the prosecuting agency, which would be the San Diego District Attorney's Office in this case. Marsy's Law also indicated that the victim needs to request case updates it does not mandate that they are uniformly provided. CLERB lacks jurisdiction over the District Attorney's Office and its employees.

Allegations 1, 2 & 4:
AYE: 10
ABSENT: 1
NAY: 0
ABSTAIN: 0

25-139/NORRIS (Priority)

1. Discrimination/Racial – An unidentified deputy "*profiled*" Quentin Norris during a traffic stop on 01-15-25.

Board Finding: Summary Dismissal
Staff Recommended Finding: Not Sustained
Rationale: Norris alleged he was stopped by an unidentified deputy on Carlsbad boulevard for speeding but was not issued a citation. Norris believed he was, "*racially profiled as a Black man.*" Per SDSO records, there was no record of a deputy conducting a traffic stop in that area on that date. The specific area described by Norris is within the city of Carlsbad and jurisdiction of Carlsbad Police. ~~The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation~~. The Review Board lacks jurisdiction or the complaint clearly lacks merit.

AYE: 10
ABSENT:1
NAY: 0
ABSTAIN: 0

2. Illegal Search or Seizure – Deputy 1 detained Quentin Norris on 04-19-25.

   Board Finding: Action Justified
   Staff Recommended Finding: Action Justified
   Rationale: Norris complained on 04-19-25 he was pulled over by Deputy 1 while driving his 2023 Tesla in Encinitas. Norris alleged, "*The vehicle had valid dealer plates, under California law, those plates are valid for 90 days from the date of purchase*." *Norris was issued a citation which he believed was, "inaccurate and not compliant with state law*." The investigation revealed Deputy 1 stopped Norris at approximately 2:00 am for multiple infractions including failure to stop at the limit line twice and failure to display the proper license plate on his vehicle. A review of Body Worn Camera (BWC) footage revealed Deputy 1 explained the reason for the stop in detail to Norris. CVC 22450(a) Special Stops Required stated, "*The driver of any vehicle approaching a stop sign at the entrance to, or within, an intersection must stop at a limit line (if marked), or before entering the crosswalk on the near side of the intersection*." Norris admitted to Deputy 1 he had received the license plates for the vehicle from DMV but had not put them on. CVC 5201(b) Temporary Plates stated "*Temporary license plates shall be replaced with permanent license plates upon receipt of the permanent license plates, and the temporary license plates shall be destroyed at that time*." Deputy 1 informed Norris he was going to issue a citation for the license plate, which was a fix it ticket instead of the stop sign which would be a moving violation and fine. SDSO P&P 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*." The investigation showed the above act did occur but was lawful, justified, and proper.

3. Discrimination/Racial – Deputy 1 "*profiled*" Quentin Norris during a traffic stop on 04-19-25

   Board Finding: Unfounded
   Staff Recommended Finding: Unfounded
   Rationale: Norris alleged he believed he was, "*racially profiled as a Black man driving a new Tesla in Encinitas*" and wrote, "*I've been stopped three times without valid cause. The pattern suggests I'm being targeted based on race and perceived as suspicious due to my appearance and car.*" See rationale #2. The investigation clearly established that the allegation is not true.

4. Misconduct/Discourtesy – Deputy 2 made inappropriate comments to Quentin Norris on 04-19-25.

   Board Finding: Unfounded
   Staff Recommended Finding: Unfounded
   Rationale: Norris alleged Deputy 2, "*jokingly asked if I had any guns, bombs, or weapons of mass destruction in the car*" and felt, "*Whether intended as humor or not, the comment was inappropriate, unprofessional, and deeply unsettling*." A review of BWC footage revealed Deputy 2 did make that statement. This question was about 9 minutes into Deputy 2's contact with Norris who was sitting in the driver's seat of his vehicle while Deputy 2 stood outside the passenger door. The tone of their interaction was conversational and included Deputy 2 asking about the Tesla and if Norris was in school. The interaction also included questions from Norris to Deputy 2 about why he became a police officer. In response to the question, Norris asked if Deputy 2 wanted to search the vehicle and Deputy 2 responded, *No, I trust you, nothing about you screams I gotta be worried*" chuckled and explained those were, "*Questions I ask everybody.*" The investigation clearly established that the allegation is not true.

Allegations 2, 3 & 4:
AYE: 7
ABSENT:1
NAY: 3
ABSTAIN: 0

26-027/MILLER for MILLS (Summary Dismissal)

1. Misconduct/Medical – Unidentified failed to provide Kevin Lamar Mills (deceased) with proper medical care.

   Board Finding: Summary Dismissal
   Staff Recommended Finding: Summary Dismissal
   Rationale: Complainant Yusef Miller signed a complaint with CLERB on 03-10-26, regarding Kevin Lamar Mills who died while in custody at San Diego Central Jail on 11-11-20. Miller requested an investigation into whether Mills received appropriate medical care during the intake process and throughout his stay in SDSO custody. CLERB completed an investigation into Kevin Mills' death and the case was closed on 02-08-22 (Ref. CLERB Case #20-108). At the time of that investigation, CLERB did not yet have jurisdiction over medical issues. Pursuant to CLERB Rules and Regulations, Section 15, Summary Dismissal, CLERB does not have jurisdiction because the complaint was not timely filed.

AYE: 10
ABSENT: 1
NAY: 0
ABSTAIN: 0

Adjourned 10:44 pm ***End of Report***