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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 **May 7, 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 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 (15)

ALLEGATIONS, BOARD FINDINGS & RATIONALES

24-032/CUNNINGHAM (Death)

1. Death Investigation/In-custody Medical – Incarcerated Person (IP) Benjamin Cunningham died on 02-25-24 from injuries sustained while incarcerated at the San Diego Central Jail (SDCJ) on 01-29-24.

   Board Finding: Approved
   Conclusion: This case was reviewed in accordance with CLERB Rules & Regulations, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. Additionally, CLERB received a signed complaint on 12-05-24. Cunningham was arrested by San Diego Police (SDPD) on 01-28-24 at approximately 1:30pm after a physical altercation with his minor son and subsequently booked into San Diego Central Jail (SDCJ) where he was classified as a Level 5 IP. Cunningham was undergoing treatment for alcohol addiction but had checked himself out earlier in the day and consumed alcohol to the point of intoxication. At the time of his booking, medical staff noted Cunningham reported, "*being an alcoholic, drinks everyday and reports liver/kidney issues.*" Per medical records, Cunningham was ordered a, "*Low bunk for safety*" and assigned the Bottom bunk, which was reflected in the Jail Information Management System (JIMS). On 01-29-24 at about 4:42am, Deputy 1 escorted IP Cunningham to his cell, located on the upper tier of the assigned module. The cell was already occupied by two Incarcerated Persons (IPs) who were lying in the Bottom and Middle bunks. Per JIMS records, those IPs were supposed to be in the Middle and Top bunks. Deputy 1 asked the IP in the Bottom bunk if he was willing to move so Cunningham could have the Bottom bunk. Neither IP made an attempt to move their bedroll and Deputy 1 told Cunningham, *"Let me check your books again."* Deputy 1 closed the cell door while Cunningham stood in the cell with his mattress on the floor. Two safety checks and meal service took place in the module, however the issue

of bunk assignments was never addressed. DSB P&P I.22 stated, "*The recommendation for a lower bunk and/or lower tier will be determined by health staff and entered into medical instructions. The health staff's order for lower bunk and/or lower tier housing is considered a housing restriction to minimize the risk of injury to the incarcerated person. Housing deputies will be responsible for assigning these incarcerated persons in the Jail Information Management Systems (JIMS) to either a lower bunk, lower tier or a lower bunk on the lower tier. At the beginning of each shift, the watch commander or designee will review the lower bunk / lower tier discrepancies report in JIMS. The watch commander or designee shall direct housing deputies to resolve any discrepancies*." Less than two hours later, at about 6:04am, Deputy 1 performed a safety check of the cell. Cunningham relayed that he fell off the top bunk and needed medical attention. Deputy 1 escorted Cunningham down the stairs, handed him off to another deputy who provided Cunningham with a wheelchair at his request and brought him to medical staff. DSB P&P M.15 stated, "*Incarcerated persons in need of urgent medical attention shall be immediately referred to health staff*." Cunningham described the fall to medical staff saying, "*I just fell off the top bunk*." Cunningham described having pain to the left side of his body stating, *"I have a lot of pain right here in my ribs, my arm got swollen and I got a big bump on the back of my head*." In response to medical staff asking if he lost consciousness, Cunningham replied, "*The guy (IP) woke me up and asked me if I wanted my mattress on the floor.*" Medical staff took x-rays of Cunningham, provided him with a rib belt for pain, and returned him to his upper tier cell. DSB P&P M.13 said, "*Detention facility qualified health providers (QHP) (e.g., physicians, nurse practitioners) are primarily responsible for the medical treatment, planning, and referral to any necessary outside medical service when deemed necessary. QHPs are also responsible for providing emergency medical care and will determine additional treatment or referral to an emergency department, if needed*." On 01-30-24, IP Cunningham was again seen in medical and assessed for continued pain, concern for concussion, Bilat icteric sclera's (yellowing of eyes) and liver issues. Per medical instructions, Cunningham was transported by deputies to a hospital. On 01-31-24, CT scans revealed, "*liver and splenic laceration with active extravasation from spleen*." Between 01-31-24 and 02-05-24, Cunningham had four medical procedures. Despite the procedures, Cunningham's condition steadily declined resulting in his death on 02-25-24. Per the Medical Examiner's report, Cunningham "*died as the result of complications of recent blunt force injury of trunk with left rib fracture and splenic laceration. Alcoholic cirrhosis with portal hypertension and splenomegaly contributed to his death. Based on the investigative information available, the manner of death is best classified as accident."* 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/Procedure – Deputy 1 failed to enforce IP Cunningham's bunk assignment.

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: Following intake medical screening, medical staff ordered Cunningham be assigned a, "*low bunk for safety*" due to medical concerns. The JIMS (Jail Information Management System) system was updated to reflect Cunningham as assigned housing in Module 5D, cell 14, Bottom bunk. Deputy 1 escorted Cunningham to cell 14 which was already occupied by two IPs who were laying in the Bottom and Middle bunks. JIMS records reflected that the IPs were assigned to the Middle and Top bunks. Deputy 1 asked the IP on the Bottom bunk, "*Hey if you mind man, ah do you have the lower bunk bro, do you know*?" The IP replied, *"me*?" and Deputy 1 said, "*yeah, are you supposed to be on the low bunk*?" The IP's reply was unintelligible and Deputy 1 responded, "*Cause if you don't I would ask you if you could move up to the top cause he* (Cunningham) *just got out of the hospital*." The IPs specific reply was unintelligible, but he essentially responded that he needed time and would not move right then. Deputy 1 responded, "*Let me check your (*Cunningham's*) books again alright"* and closed the cell door as Cunningham stood in the cell. Though deputies performed safety checks, there was no evidence that Deputy 1 or any other deputy addressed the bunk assignments and Cunningham fell off the top bunk approximately three hours later. DSB P&P I.22, Lower Bunk Assignment, stated, "*The recommendation for a lower bunk and/or lower tier will be determined by health staff and entered into medical instructions. The health staff's order for lower bunk and/or lower tier housing is considered a housing restriction to minimize the risk of injury to the incarcerated person. Housing deputies will be responsible for assigning these incarcerated persons in the Jail Information Management Systems (JIMS) to either a lower bunk, lower tier or a lower bunk on the lower tier. At the beginning of each shift, the watch commander or designee will review the lower bunk / lower tier discrepancies report in JIMS. The watch commander or designee shall direct housing deputies to resolve any discrepancies*." Deputy 1 also provided a confidential statement that was taken into consideration. The investigation disclosed evidence sufficient to prove the allegation by a preponderance of the evidence.

3. Misconduct/Medical – Medical staff failed to identify IP Cunningham's life-threatening injuries resulting in delay of treatment.

   Board Finding: Summary Dismissal
   Staff Recommended Finding: Summary Dismissal
   Rationale: Complainant Pamela Cunningham alleged staff delayed medical treatment of Cunningham. See Rationales 1 & 3. Medical Staff are non-sworn personnel. At the time of this incident, CLERB did not have jurisdiction over health care providers. Pursuant to CLERB Rules and Regulations, 4.1, Complaints: Authority, 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… CLERB does not have jurisdiction over the subject matter of the allegation.

4. Misconduct/Procedure – Unidentified deputies placed IP Cunningham into a cell with "violent people".

   Board Finding: Unfounded
   Staff Recommended Finding: Unfounded
   Rationale: The complainant alleged IP Cunningham was inappropriately placed into a cell with violent people. Cunningham was classified as a general population Level 5 IP and housed with two other IP's classified as Levels 4 and 5. DSB P&P R.1, Incarcerated Person Classification, stated, "*The Jail Population Management Unit (JPMU) will conduct classification assessments, assign individuals a classification, and assign housing for all incarcerated persons. An incarcerated persons 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. The incarcerated person will be assigned to the most appropriate housing location based on their classification designation. Incarcerated persons with custody levels 1, 2, or 3 can be housed together. Levels 4 and 5 can be housed together. Level 6 incarcerated persons will be housed in Administrative Segregation*." The evidence shows that the alleged act or conduct did not occur.

5. Misconduct/Procedure – Unidentified deputies failed to conduct proper safety checks.

   Board Finding: Unfounded
   Staff Recommended Finding: Unfounded
   Rationale: The complainant alleged deputies failed to conduct proper safety checks. Per CCTV, IP Cunningham was placed into his cell at approximately 2:42am. Six checks of the module were conducted including delivery of breakfast to each cell between 2:42am, and when deputies responded to Cunningham's intercom notification at approximately 6:07am. DSB P&P 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*." The evidence shows that the alleged act or conduct did not occur.

AYE: 8
ABSENT: 3
NAY: 0
ABSTAIN: 0

24-036/KAMARA (Death)

1. Death Investigation/In-Custody Medical – Abdul Kamara died while in the custody of the San Diego Sheriff's Office (SDSO) on 03-03-24.

   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. On 03-02-24, at approximately 9:13pm, Carlsbad Police Department officers and emergency medical services (EMS) personnel responded to a call for a welfare check of Abdul Kamara outside of a Carl's Jr. in Carlsbad. Upon arrival, EMS personnel were unable to locate Kamara. However, while EMS personnel were returning to their station, they were flagged down by Kamara, who was now at a parking lot of a Jack in the Box. When EMS personnel contacted Kamara, he exhibited signs of paranoia and asked to be taken to a hospital. Kamara did not exhibit any signs of medical distress. At the hospital,

Kamara refused care and fled the hospital on foot. Hospital security staff were unable to locate Kamara. Hospital staff called 911 to report Kamara had refused care and fled the hospital on foot. SDSO deputies responded to the hospital, interviewed hospital staff, and were unable to locate Kamara in the surrounding area. Deputies learned from hospital staff that Kamara was not placed on any type of medical or 5150 hold. Additionally, the doctor who attempted to treat Kamara did not wish to report Kamara as a missing person. CA Welfare and Institutions Code Section 5150 provides that a qualified person may, upon probable cause, take, or cause to be taken, a person into custody for a period of up to 72 hours for assessment, evaluation, and crisis intervention. 03-02-24, at approximately 11:45pm, an employee at a Valero gas station in Cardiff, CA, called 911 to report an individual, later identified as Kamara, with "*no shirt, no shoes… crawling through the parking lot… he has a wristband from the hospital near by… I think he might of… left prematurely from… the psychiatric… support place we have nearby…*" Deputies responded to the gas station and detained Kamara at approximately 11:57pm. During the contact with Kamara at the gas station, a deputy stated, "*we're just trying to get you some help, alright?*" Kamara responded, "*I don't need help at the hospital." A deputy responded,* "*…they're going to evaluate you*" Kamara stated, "*no, no, no, I declined… no, I'm not going to the hospital. I'd rather go to jail than hospital*." A deputy stated, "*before they do that, we got to get you checked out at the hospital.*" Kamara responded, "*no I don't need to get checked out. I'm okay… I don't consent that. I don't consent taking me to the hospital… don't take me to the hospital… I'd rather go to jail…*" During the deputies contact with Kamara, Kamara was cooperative and did not appear to be in medical distress. Ultimately, deputies determined Kamara was under the influence of a controlled substance and subsequently arrested Kamara, at approximately 12:22am, on 03-03-24. Kamara was transported to Vista Detention Facility (VDF), arriving at approximately 12:43am. While awaiting processing, Kamara became combative with deputies. A nearby California Highway Patrol (CHP) officer, as well as VDF deputies responded to assist. Due to the level of resistance offered by Kamara, deputies secured Kamara using a WRAP restraint device. Prior to placement in the WRAP, EMS personnel were called to assess Kamara, as Kamara sustained a self-inflicted injury to his forehead during the incident. On 03-03-24, at approximately 12:57am Kamara was successfully placed in the WRAP. At approximately 1:13am, EMS personnel arrived on scene and shortly after began assessing Kamara. Kamara was monitored by deputies while placed in the WRAP. While EMS personnel were evaluating Kamara, Kamara suffered a medical emergency. At approximately 1:30am, it was announced that Kamara needed "CPR." Life-saving measures were taken, and, at approximately 1:32am, Kamara was placed in the ambulance and transported to a hospital. Kamara continued to receive treatment at the hospital. Kamara was pronounced deceased on 03-03-24 at 4:03am. Interviews with EMS personnel described Kamara as awake, talking, and responsive at the time they initiated their medical assessment. Multiple witnesses described Kamara's verbal responses as present but nonsensical or altered. Multiple witnesses reported that Kamara became less responsive during the assessment, was no longer verbal, and ultimately became pulseless. Per CA HSC Section 11550 (a), "*A person shall not use, or be under the influence of any controlled substance… except when administered by or under the direction of a person licensed by the state to dispense, prescribe, or administer controlled substances. It shall be the burden of the defense to show that it comes within the exception. A person convicted of violating this subdivision is guilty of a misdemeanor and shall be sentenced to serve a term of not more than one year in a county jail. The court may also place a person convicted under this subdivision on probation for a period not to exceed five years*." Per SDSO P&P Addendum Section F, Use of Force Guidelines, WRAP Restraint Device, "*The WRAP restraint device may be used on violent subjects who, by kicking, pose a threat to themselves, others, or to equipment. Additionally, it may be used in lieu of leg chains to hobble subjects who present an escape risk. The WRAP restraint device may be used on violent subjects that are not controlled by other means. Application of the WRAP restraint device results in restricted movement of both the hands and feet. Following the application of the WRAP restraint device, the subject shall be rolled onto their side or into an upright, seated position as soon as possible. When placing a subject in the WRAP restraint device, one deputy shall be designated as the "safety deputy" if feasible. The safety deputy's sole responsibility is to monitor the health and safety of the subject being placed into the restraint device. If at any time during the placement, the safety deputy determines the subject may be in immediate physical distress, such that the subject may suffer serious bodily injury or death, the safety deputy shall immediately intervene to render aid and/or seek emergency medical assistance*." Per the Medical Examiner Report, "…*the cause of death is certified as complications of resuscitated cardiopulmonary arrest due to acute methamphetamine intoxication with sickle cell anemia listed as contributing. The manner of death is accident*." A review of this incident found that SDSO deputies made a lawful arrest of Kamara. Additionally, the review showed use of a WRAP during the incident was within policy and procedure.

2. Misconduct/Procedure – Deputies 1 and 2 failed to activate their Body Worn Camera (BWC) in accordance with SDSO policy.

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: During CLERB's investigation, it was noted Deputies 1 and 2 did not activate their Body Worn Cameras (BWC) in accordance with SDSO P&P. Deputies 1 and 2 both deactivated their BWCs following Kamara's placement in the WRAP, as they briefly left the area while Kamara was monitored by other deputies present. However, as Deputies 1 and 2 retuned to Kamara's location, Deputy 2 began recording on his BWC and subsequently muted it, and Deputy 1 did not begin recording again until Kamara went into medical distress while with EMS personnel. "*Deputies/CSO's should also begin recording prior to initiating any law enforcement related contact. Deputies/ CSO's shall activate the BWC to record all law enforcement related contacts… Law enforcement related contacts include but are not limited to the following: traffic stops, field interviews, vehicle tows, issuing of citations, issuing of parking tickets, detentions, arrests, persons present at radio calls who are accused of crimes, serving court orders or civil papers, investigative interviews, deputy initiated consensual encounters and private person-initiated contacts of a confrontational nature…. 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… In all cases where BWC video is muted, it shall be documented in writing*…" The investigation disclosed evidence sufficient to prove the allegation by a Preponderance of the Evidence.

AYE: 8
ABSENT: 3
NAY: 0
ABSTAIN: 0

24-123/CAMACHO (Death)

1. Death Investigation/Restraint-Related – Angela Camacho was placed in a WRAP device on 08-14-24, became unresponsive and subsequently died on 09-16-24.

   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. On 08-14-24, deputies received a radio call of two women physically fighting in front of a convenience store. The reporting party observed Camacho displaying erratic behavior. Deputies arrived and reported Camacho as *"extremely agitated and sweating profusely."* Camacho ran and a deputy deployed his taser (CED), but the probes failed to make contact with Camacho. Camacho stopped, turned, and faced deputies while *"yelling, flailing her arms, and pointing her finger aggressively."* Camacho was instructed to place her hands behind her back but did not comply. Deputies grabbed Camacho's hands, but she pulled away. A deputy then pulled Camacho to the ground and she collapsed, hitting her head on the pavement. Once on the ground, Camacho continued to be combative and a WRAP restraint device was requested. Deputies placed Camacho in the WRAP, and she made *"grunting"* sounds during the application process which took almost five minutes. Once Camacho was secured in the WRAP, a deputy noted she was very quiet and checked but was unable to locate a pulse and summoned medics who were on scene. The WRAP was removed from Camacho and CPR was started. Camacho's pulse came back and she was transported to a hospital and admitted to the Intensive Care Unit (ICU). Camacho's health deteriorated while hospitalized, and she was compassionately released from Sheriff's custody and transferred to a Community Care Facility for Hospice care. She was pronounced deceased on 09-16-24. The Medical Examiner's Office determined the cause of death was *anoxic-ischemic encephalopathy* (severe brain dysfunction caused by lack of oxygen) *due to resuscitated cardiopulmonary arrest during law enforcement restraint and methamphetamine intoxication, with hypertensive and atherosclerotic cardiovascular disease and class 2 obesity as contributing conditions.* Per CLERB Rules & Regulations 16.1, at the conclusion of a matter before the entire CLERB, CLERB shall deliberate and adopt a final report ("Final Report") with respect to the case or matter under consideration. This report shall include findings as to the facts relating to any case, as well as an overall conclusion as to any case as specified in Section 16.2.

AYE: 6
ABSENT: 3
NAY: 2

ABSTAIN: 0

Dissent

I, Adele Fasano, member of the County Law Enforcement Review Board, voted no to the recommendations which were approved by a majority of board members at the May 7, 2026 meeting on case 24-123. The below is my dissenting opinion based on my determination that policies of the San Diego Sheriff's Department were violated which led to the death of the subject of this case. Officers have a duty to not take measures which jeopardize the life of an individual when other actions are available to gain compliance from a subject. They also have the responsibility to ensure that life-saving measures are taken immediately. The basic issue is that the wrap device, which is essentially a full body straight jacket, was placed on the individual based on the justification that the subject was resisting arrest by flailing her arms and legs. This device does not provide for adjustments based on the subject's heights and weight. In this case the device caused her difficulty breathing as it was so tight around her chest. that it greatly impeded her ability to breathe. This is confirmed by the Medical Examiners findings on the cause of death which was " severe brain disfunction caused by lack of oxygen due to cardiopulmonary arrest during law enforcement restraint and methamphetamine intoxication." Based on her death I believe it is evident that the officers did not respond promptly to remove the device to avert the emergency but also should have recognized that it was insufficient size to safely place on her. The Officers should have also recognized that the device was so tight around the subject's torso that it provided a serious risk of her being able to breathe. Hence they should have used alternative restraint methods. The Sheriff's Department should develop strict guidelines on what size individuals may be safely placed in the "wrap" and when used, ensure there is constant surveillance so that lifesaving actions are taken immediately if it impedes breathing. If it does not fit properly, alternative methods of restraint should be used to gain compliance from the subject.

- Motion for staff to provide research and training on the WRAP device.

AYE: 8
ABSENT: 3
NAY: 0
ABSTAIN: 0

25-009/PINSKY (GBI)

1. Serious Misconduct/Excessive Force – Deputy Jeremiah Flores used force against Incarcerated Person (IP) Jonathan Pinsky on 08-29-24.

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 08-29-24, Deputy 4 escorted IP Pinsky from a court appearance to a holding cell at the San Diego Central Courthouse. During the escort, Deputy 4 used force against IP Pinsky when he used both hands to shove IP Pinsky through the open cell doorway. As a result of Deputy 4's shove, IP Pinsky stumbled forward into the cell's metal bench. IP Pinsky's head appeared to strike the cement wall at the back of the cell, and his body became limp and he immediately slumped to his right side where the back right side of his head struck the cement wall. IP Pinsky was seen lying motionless on his back on the floor of the cell and he appeared unconscious. The door to the cell was shut without Deputy 4 entering or assessing IP Pinsky for any injuries or verbally confirming with IP Pinsky that he was uninjured. IP Pinsky was later discovered by a deputy in his cell with visible injuries to his head that coincide with the use of force incident that occurred with Deputy 4. IP Pinsky was ultimately transported to a hospital for his injuries. Confidential statements from deputies present during the incident were considered. On 01-31-25, the US Attorney's Office initiated a press release detailing the incident and IP Pinsky's injuries were described as having "suffered a spinal injury for which he underwent surgery and remained hospitalized for months." Per SDSO P&P Addendum F: Use of Force Guidelines: *It shall be the policy of this Department that any Deputy Sheriff, in the performance of his/her official law enforcement duties, who has reasonable cause to believe that the person to be arrested has committed a public offense may use objectively reasonable force to effect the arrest, to prevent escape, or to overcome resistance. Deputies shall not lose their right to self-defense by the use of objectively reasonable force to effect an arrest, prevent escape, or overcome resistance (per 835a(d) P.C.). The use of force and subsequent reporting must be in accordance with the procedures set forth in these guidelines (see also Policy and Procedures Section 6.48). 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. Proportional force does not require officers to use the same type or amount of force as the subject. The more immediate the threat and the more likely the threat will result in death or serious physical injury, the greater the level of force that may be proportional, objectively reasonable, and necessary to counter it. Regardless of the type of force used by a deputy, the force used should always be proportional to the threat perceived by the deputy. The investigation disclosed evidence sufficient to prove the allegation by a Preponderance of the Evidence.

2. Misconduct/Procedure – Deputy 4 failed to provide medical care to Jonathan Pinsky on 08-29-24.

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: See Rationale 1. Following the use of force, IP Pinsky was seen lying on his back on the floor of the cell and did not appear to be conscious. The door to the cell was shut without Deputy 4 entering the cell or assessing IP Pinsky for any injuries or confirming with IP Pinsky that he was awake and uninjured. After the door was shut, Deputy 4 was seen briefly looking through the cell door's glass window before walking away. Immediately following this incident, Deputy 4 did not obtain medical attention for IP Pinsky, and he did not notify a supervisor that a use of force had occurred. Per SDSO P&P Addendum F: Reporting Use of Force, "*Whenever a subject requires or reasonably requests medical attention after a use of force incident, a deputy shall provide medical attention, request medical aid, and/or transport them to a medical facility as soon as it is safe and practical*." The investigation disclosed evidence sufficient to prove the allegation by a preponderance of evidence.

3. Serious Misconduct/Dishonesty – Deputy Jeremiah Flores made false and misleading statements in his reports.

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: See Rationale 1. On 08-29-24, Deputy 4 initially documented his interaction with IP Pinsky in an Inmate Status Report (ISR). In the ISR, Deputy 4 claimed to have given Pinsky verbal instructions and *"nudged him lightly"* and in response *"Pinsky rushed forward towards the cell bench and dropped on his knees and laid on the ground."* Deputy 4 also documented in the ISR, *"no force was used".* On 09-03-24, Deputy 4 was instructed by a supervisor to complete a Use of Force Report. Deputy 4's Use of Force report contradicted his ISR. In his Use of Force Report, Deputy 4 reported "*I used both of my hands on his upper back and pushed him into the cell'* and *"As a result, Pinsky stumbled forward losing his footing and fell to the floor on his knees in front of the cell bench. He then slid from the bench to the floor and landed on his right side."* In his Use of Force Report Deputy 4 changed his initial statement that force was not used and stated, "*The force used to guide Pinsky through the hallways and into the cell was necessary to overcome his active resistance and necessary to defend myself."* Deputy 4 stated he issued commands to IP Pinsky. A review of BWC footage confirmed no verbal commands were provided. Per SDSO P&P Section 2.41, Office Reports*: Employees shall submit all necessary reports on time and in accordance with established Office procedures. Reports submitted by employees shall be truthful and complete; no employees shall knowingly enter or cause to be entered any inaccurate, false, or improper information, nor omit pertinent information reasonably expected to be included."* The investigation disclosed evidence sufficient to prove the allegation by a preponderance of evidence.

4. Serious Misconduct/Failure to Intervene - Deputy Ruben Aldamapolanco failed to comply with SDSO's Duty to Intercede policy.

   Board Finding: Sustained
   Staff Recommended Finding: Not Sustained
   Rationale: See Rationale 1. Deputy 1 was present when Deputy 4 escorted IP Pinsky to his holding cell. During the escort, Deputy 4 used two hands to shove IP Pinsky into an open cell. The use of force unfolded without warning and lasted a matter of seconds. Based on ~~Deputy 1's written report and~~ CCTV footage verifying his positioning behind the cell door in the moments leading up to Deputy 4's use of force, it is more likely than not ~~view may have been partially obstructed, and it was unclear if~~ he observed Deputy 4 use force and ~~or any~~ injuries to the IP. Confidential statements were considered for the recommended finding. Per SDSO P&P 2.57, Duty to Intercede: *As a Sheriff's Department employee, we represent our organization and are accountable for upholding Department values to maintain public trust. Sworn staff employees have tremendous authority and that authority*

must be balanced with responsibility to meet the high standards of the communities we serve. Department training, expectations, and practices require intervention when sworn employees witness or have knowledge of criminal activity (i.e., misdemeanor or felony crimes) or potential excessive force by any department employee or sworn law enforcement officer. Potential excessive force is defined as force that an employee believes to be beyond that which is necessary, taking into account the possibility other deputies may have additional information regarding the threat posed by a subject. Sworn Staff- Any on-duty sworn staff employee who has knowledge of another employee's criminal activity or potential excessive force, has a duty to intercede and immediately report the activity to a supervisor. A sworn staff employee that has received all required training on the requirement to intercede, and who fails to act upon observing another employee using force that is clearly beyond that which is necessary shall be disciplined up to and including in the same manner as the deputy that committed the excessive force. ~~The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.~~ The investigation disclosed evidence sufficient to prove the allegation by a preponderance of evidence.

AYE: 8
ABSENT: 3
NAY: 0
ABSTAIN: 0

5. Misconduct/Procedure – Deputy 1 failed to provide medical care to IP Pinsky on 08-29-24.

Board Finding: Sustained
Staff Recommended Finding: Not Sustained
Rationale: Following a use of force incident involving IP Pinsky and Deputy 4, IP Pinsky sustained injuries and did not immediately receive medical attention. See Rationale 1. Deputy 1 was positioned several feet to the left of Deputy 4 when the incident occurred. Based on ~~Deputy 1's written report and~~ CCTV footage verifying his positioning behind the cell door in the moments leading up to Deputy 4's use of force, it is more likely than not ~~his view may have been partially obstructed, and it was unclear if~~ Deputy 1 observed injuries to IP Pinsky. ~~Deputy 1's view of Deputy 4's actions and the interior of the cell may have been partially obstructed by his position in relation to the cell door. As a result of his partially obstructed view, it was unclear if Deputy 1 was aware IP Pinsky sustained injuries~~. Confidential statements were considered. SDSO P&P Addendum F: Reporting Use of Force- *Whenever a subject requires or reasonably requests medical attention after a use of force incident, a deputy shall provide medical attention, request medical aid, and/or transport them to a medical facility as soon as it is safe and practical*. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation. The investigation disclosed evidence sufficient to prove the allegation by a preponderance of evidence.

AYE: 8
ABSENT: 3
NAY: 0
ABSTAIN: 0

6. Serious Misconduct/Failure to Intervene - Deputy Jose Calderon Jr. failed to comply with SDSO's Duty to Intercede Policy.

Board Finding: Sustained
Staff Recommended Finding: Sustained
Rationale: See Rationale 1. Deputy 2 was present when Deputy 4 escorted IP Pinsky to his holding cell. During the escort, per Deputy 2's Officer Report he stated "*I observed Deputy 4 use both hands to push Pinsky inside cell J4 so that the cell door could safely close behind him. I watched him stumble and fall to his knees on the ground. The door closed behind Pinsky and I had no further contact with him."* Per BWC Footage, the use of force unfolded without warning and lasted a matter of seconds. A review of CCTV footage showed Deputy 2 had a clear view of the interior of the cell and would have had a visual of Deputy 4's actions and of IP Pinsky colliding into the bench and cement wall and ultimately landing on the floor where he remained until the cell door was shut. Deputy 2 did not report Deputy 4's use of force to a supervisor. Per SDSO P&P 2.57, Duty to Intercede: *As a Sheriff's Department employee, we represent our organization and are accountable for upholding Department values to maintain public trust. Sworn staff employees have tremendous authority and that authority must be balanced with responsibility to meet the high standards of the communities we serve. Department training, expectations, and practices require intervention when sworn employees witness or have knowledge of criminal activity (i.e., misdemeanor or felony crimes) or potential excessive force by any department employee or sworn law enforcement officer. Potential excessive force is defined as force that an employee believes to be beyond that which is necessary, taking into account the possibility other deputies may have additional information regarding*

the threat posed by a subject. Sworn Staff- Any on-duty sworn staff employee who has knowledge of another employee's criminal activity or potential excessive force, has a duty to intercede and immediately report the activity to a supervisor. A sworn staff employee that has received all required training on the requirement to intercede, and who fails to act upon observing another employee using force that is clearly beyond that which is necessary shall be disciplined up to and including in the same manner as the deputy that committed the excessive force. The investigation disclosed evidence sufficient to prove the allegation by a preponderance of evidence.

7. Misconduct/Procedure – Deputy 2 failed to provide medical care to IP Pinsky on 08-29-24.

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: Following a use of force incident, IP Pinsky sustained injuries and did not immediately receive subsequent medical attention. See Rationale 1. Deputy 2 had an unobstructed view of Deputy 4's actions and of the interior of the cell following the use of force. Following the use of force, IP Pinsky collided into the bench and cement wall at the back of the cell, IP Pinsky appeared to lose consciousness, and he slumped over to his right side where the back right side of his head could be seen striking a cement wall. IP Pinsky did not get back up nor did he appear conscious, he remained on the floor of the cell when the cell door was closed. Deputy 2 did not call for medics to respond, nor did he provide medical aid to IP Pinsky. Confidential statements were considered. Per SDSO P&P Addendum F: Reporting Use of Force, "*Whenever a subject requires or reasonably requests medical attention after a use of force incident, a deputy shall provide medical attention, request medical aid, and/or transport them to a medical facility as soon as it is safe and practical*." The investigation disclosed evidence sufficient to prove the allegation by a preponderance of evidence.

8. Serious Misconduct/Dishonesty – Deputy Jose Calderon Jr.'s Officer's Report dated 09-03-24 was inaccurate.

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: Refer to Rationale 1. Deputy 2 witnessed Deputy 4 use force against IP Pinsky on 08-29-24. Deputy 2 stated in his Officer Report, "*I observed Deputy 4 use both hands to push Pinsky inside cell J4 so that the cell door could safely close behind him. I watched him stumble and fall to his knees on the ground. The door closed behind Pinsky and I had no further contact with him."* A review of CCTV footage showed Deputy 2 had an unobstructed view of Deputy 4's actions and of the interior of the cell. CCTV footage showed Deputy 2 would have had a visual of IP Pinsky colliding into the bench and cement wall at the back of the cell. CCTV footage also showed Deputy 2 would have had a view of IP Pinsky lying motionless on his back on the floor before the cell door was shut. Deputy 2 failed to include details such as IP Pinsky forcefully colliding into the back of the cell as a result of the force used and failed to include that IP Pinsky was lying motionless on the floor before the cell door was shut in his written report. Confidential statements were considered for the recommended finding. Per SDSO P&P Section 2.41 Office Reports: "*Employees shall submit all necessary reports on time and in accordance with established Office procedures. Reports submitted by employees shall be truthful and complete; no employees shall knowingly enter or cause to be entered any inaccurate, false, or improper information, nor omit pertinent information reasonably expected to be included."* The investigation disclosed evidence sufficient to prove the allegation by a preponderance of evidence.

9. Misconduct/Procedure – Deputies 1 and 2 failed to activate their Body Worn Camera (BWC's) on 08-29-24.

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: See Rationale 1. Deputies 1 and 2 did not activate their BWC's while assisting Deputy 4 with escorting IP Pinsky to his holding cell. Confidential statements were considered. Per SDSO P&P Section 6.131, Body Worn Camera, "*The body-worn camera (BWC) is an "on-the-body" audio and video recording system assigned to a deputy sheriff or community services officer (CSO) as an additional means of documenting specific incidents in the field Law Enforcement Services Bureau (LESB), Court Services Bureau (CSB), and Detention Services Bureau (DSB). Deputies/CSO's are responsible for knowing and complying with this procedure and applicable bureau specific manuals and procedures."* Per SDSO DSB I.20, Supplemental Guidelines for Detentions: Body Worn Camera, *"(a) Deputies shall activate their BWCs in accordance with San Diego Sheriff's Department Body Worn Camera Policy and Procedure 6.131, as well as whenever possible, prior to engaging in and for the entire*

duration of the performance of the following duties 1. Any movements or escorts of incarcerated persons from one area to another (cell movements, between housing modules, holding cells, visitation, courts, from intake or to final release, etc.)" The investigation disclosed evidence sufficient to prove the allegation by a preponderance of evidence.

10. Misconduct/Procedure – Deputy 3 failed to activate their Body Worn Camera (BWC's) during a safety check on 08-29-24.

    Board Finding: Sustained
    Staff Recommended Finding: Sustained
    Rationale: See Rationale 1. Deputy 3 completed a safety check on 08-29-24. Through the course of the investigation it was discovered there was no BWC footage of Deputy 's safety check. Confidential statements were considered. Per SDSO P&P 6.131, Body Worn Camera: "*The body-worn camera (BWC) is an "on-the-body" audio and video recording system assigned to a deputy sheriff or community services officer (CSO) as an additional means of documenting specific incidents in the field Law Enforcement Services Bureau (LESB), Court Services Bureau (CSB), and Detention Services Bureau (DSB). Deputies/ CSO's are responsible for knowing and complying with this procedure and applicable bureau specific manuals and procedures."* Per SDSO DSB P&P I.20, Supplemental Guidelines for Detentions: Body Worn Camera, *"(a) Deputies shall activate their BWCs in accordance with San Diego Sheriff's Department Body Worn Camera Policy and Procedure 6.131, as well as whenever possible, prior to engaging in and for the entire duration of the performance of the following duties: 2. Entering a cell, dormitory housing, or holding area occupied by an incarcerated person. These situations include, but are not limited to: t c)11-53 Safety Checks".* The investigation disclosed evidence sufficient to prove the allegation by a preponderance of evidence.

Allegations 1-3 & 6-10
AYE: 8
ABSENT: 3
NAY: 0
ABSTAIN: 0

25-058/RICHARDSON (Summary Dismissal)

1. False Reporting – Deputy 1 wrote a *"false"* police report.

   Board Finding: Summary Dismissal
   Staff Recommended Finding: Summary Dismissal
   Rationale: Complainant Daneille Richardson alleged *"Deputy 1 engaged in the crime of perjury when he wrote a false police report."* Richardson referenced a traffic stop that occurred on 11-23-24, which CLERB previously investigated and presented, deliberated and closed by the Review Board on 08-07-25, CLERB case #24-177. There was no crime report written regarding Richardson from the traffic stop on 11-23-24. The case written listing Richardson as a suspect was dated 01-03-24. Richardson stated in her current complaint that the *"DA ultimately admitted I never did anything wrong."* Regardless of the DA's findings, this traffic stop occurred on 01-03-24, and Richardson's complaint was filed on 05-13-25. Pursuant to CLERB Rules and Regulations, Section 15, Summary Dismissal, Section 4.1.2, 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. CLERB does not have jurisdiction because the complaint was not timely filed.

AYE: 8
ABSENT: 3
NAY: 0
ABSTAIN: 0

25-064/POWELL (Summary Dismissal)

1. Misconduct/Procedure – PO 1 did not respond to Powell's request(s).

   Board Finding: Summary Dismissal
   Staff Recommended Finding: Summary Dismissal
   Rationale: The complainant, Aneesha Powell, alleged that San Diego County Probation personnel did not adequately respond to reports of ongoing harassing phone calls from an individual reportedly under Probation

supervision. The complaint describes ongoing phone contact from an individual, which Powell characterized as threatening and harassing. Powell explained the individual is on "active formal probation" and is an ex-boyfriend from approximately five years prior to the filing of the CLERB complaint. Powell also filed a complaint with Probation. Powell stated she filed a formal complaint with the Probation Department on 04-09-25 regarding the individual's actions. CLERB is not entitled to the Probation records of the individual named in Powell's complaint, if any exists, as Powell is not authorized to sign for the records release. However, CLERB did receive a copy of a Probation Internal Affairs (IA) letter, dated 05-06-25, sent to Powell. The IA letter confirmed Probation conducted an investigation into Powell's complaint, finding that Probation staff "did their due diligence and acted in good faith in the matters you reference in your complaint." Additionally, CLERB received information from Probation that Powell was advised that Probation is not a "first-line law enforcement agency" and cannot enforce laws beyond court-ordered probation conditions. Additionally, Powell was instructed to file a restraining order, which would be a court order and something the Probation Department could enforce. CLERB lacks jurisdiction as the Probation Department is not the agency responsible to respond to Powell's requests. Pursuant to CLERB Rules and Regulations, Section 15, Summary Dismissal, CLERB investigators determined CLERB does not have jurisdiction over the subject matter of the complaint.

AYE: 8
ABSENT: 3
NAY: 0
ABSTAIN: 0

25-065/JOSEPH (Priority)

1. Illegal Search & Seizure – Deputy 2 conducted a traffic stop on 01-06-25.

   Board Finding: Action Justified
   Staff Recommended Finding: Action Justified
   Rationale: Complainant Jovannie Joseph reported, *"…I notice in my mirror he is running my plates to find a traffic violation…he proceed to follow me all from 2 minutes to 10 minutes. Then pulls me over to say that my tints are not legal. He never check my tints with the CHP. And he never gave me a tint ticket."* On 01-06-25 Deputy 2 conducted a traffic stop on the vehicle for violation of CVC 26708(a): *A person shall not drive any motor vehicle with any object or material placed, displayed, installed, affixed, or applied upon the windshield or side or rear windows*." Deputy 2 advised the driver, "*My name is Deputy 2, I work for the Sheriff's office. The reason I am stopping you today is for the tint on your front window."* BWC video verified tint was visible on both the driver and passenger front windows of the vehicle. Deputies have the authority to conduct traffic stops and there is no requirement for Deputy 2 to "check" with the CHP. During the stop, the driver did not truthfully identify his name, date of birth, address, or driver's license number. Deputy 2 attempted a variety of methods to identify the driver's true identity. The driver did not have a physical license in his possession but showed Deputy 2 a photo of a driver's license with the name "Cesar Smith." The photo on the license matched the driver. The driver verbally identified himself as Cesar Smith and provided a date of birth. Deputy 2 conducted a variety of records checks to verify the driver's identity. None of his efforts yielded a valid California driver's license nor did the efforts confirm the driver's identity. After failing to verify the driver's identity, Deputy 2 detained the driver. A mobile fingerprint scanner was utilized and identified the driver as Jovannie Joseph. Deputy 2 did not issue Joseph a citation for the window tint, instead Joseph was arrested for Identity Theft, for utilizing another individual's driver's license number as his own, and Providing False Information of Another to a Peace Officer. Per SDSO Patrol Procedures Manual Policy 1 Use of Discretion: *When Deputies are faced with a situation where discretion can be exercised, they must evaluate the circumstances, consider the available resources, and rely on their training, Sheriff's Department policies and procedures, statutory law, information-led policing, and supervision in making the appropriate decision.* After search incident to arrest of Joseph's person and vehicle, Joseph was booked into Central Jail for Identity Theft, Providing False Information of Another Person to a Peace Officer, Possess/Purchase for Sale Narcotic/Controlled Substance, Transport/Sell Narcotic/Controlled Substance, Possession of a Controlled Substance for Sales, Transporting Controlled Substances for Sales, and Possession for Sales Designated Controlled Substance. The investigation showed the alleged act did occur but was lawful, justified, and proper.

2. Misconduct/Discourtesy – Deputy 2 "*defamed and slandered*" Joseph.

   Board Finding: Unfounded
   Staff Recommended Finding: Unfounded

Rationale: Complainant Jovannie Joseph reported, "*...they gave it to Undercovers and they went to all the addresses in my phone and was kicking on doors talking to the people I know and embarked on spreading propaganda and I was a victim of defamation and slander.*" Deputy 2 conducted phone follow-up interviews with the victims of identity theft. Deputy 2 and a Special Agent with The Department of Homeland Security conducted interviews and asked questions pertaining to relationships and knowledge of Joseph and the context of the phone dialogue with regards to the ongoing investigation. The investigation did not identify "undercover" law enforcement involvement in conducting additional follow up. Per SDSO P&P 2.55 Non-Biased Based Policing: *All investigative detentions, traffic stops, arrests, searches, and seizures of property by employees will be based on a standard of reasonable suspicion or probable cause as required by the Fourth Amendment of the U.S. Constitution, applicable case law and relevant statutory authority. Employees must be able to articulate specific facts and circumstances, which support probable cause for an arrest or search or reasonable suspicion for a traffic stop, or detention.* The investigation clearly established that the allegation is not true.

3. False Reporting – Deputy 2 documented inaccurate information in a search warrant.

   Board Finding: Unfounded
   Staff Recommended Finding: Unfounded
   Rational: Per Jovannie Joseph's complaint, *"The only way the Supreme Court approved a warrant for my phones was from false paperwork and he reported 4 phones. I only had 3 phones."* See Rationale 1. Per BWC and photographs taken at the scene, three phones were found in Joseph's vehicle, and one phone was on Joseph's person. Search warrants were authorized to forensically examine the four phones by San Diego County judges. Joseph was notified of the search warrants for the four phones per Electronic Communication Privacy Act (ECPA) requirements. Per SDSO P&P 2.41 Office Reports:...*Reports submitted by employees shall be truthful and complete; no employee shall knowingly enter or cause to be entered any inaccurate, false, or improper information, nor omit pertinent information reasonably expected to be included.* The investigation clearly established that the allegation is not true.

4. Misconduct/Intimidation - Deputy 2 threatened Joseph during a traffic stop on 01-06-25.

   Board Finding: Unfounded
   Staff Recommended Finding: Unfounded
   Rationale: Complainant Jovannie Joseph alleged, *"…and he just kept saying I'm going to put you in jail for a long time."* See Rationale 1. The interaction between Deputy 2 and Joseph was captured on BWC. Deputy 2 was not heard making the alleged statement. During the interaction Deputy 2 commented on how appreciative he was that Joseph was compliant and respectful. 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*. The investigation clearly established that the allegation is not true.

5. False Reporting - Deputy 2 wrote inaccurate information in a report.

   Board Finding: Unfounded
   Staff Recommended Finding: Unfounded
   Rationale: Complainant Jovannie Joseph alleged, *"What he found in my car were pills, marijuana, flower pins, gummies, mushroom edibles. The amount was all small. The pills were about 2-7 each. On the report he put 56 Xanax pills and added a whole lot of names that I do not know."* See Rationale 1. Deputy 2's BWC video recording was activated during the search, Deputy 4 assisted in the search and also had their BWC video on. Additionally, Deputy 2 took photos of the narcotics found in the vehicle and on Joseph's person. The crime report documented 150 pills and 24 suspected Xanax bars. This was consistent with the BWC and photographs. Per SDSO P&P 2.41 Office Reports:...*Reports submitted by employees shall be truthful and complete; no employee shall knowingly enter or cause to be entered any inaccurate, false, or improper information, nor omit pertinent information reasonably expected to be included.* The investigation clearly established that the allegation is not true.

6. Criminal Conduct – Deputy 2 stole money from Joseph on 01-06-25.

Board Finding: Unfounded
Staff Recommended Finding: Unfounded
Rationale: Complainant Jovannie Joseph alleged, *"He stole 8,000 of my money. Only counted 2,000 on camera and reported 5,000."* See Rationale 1. BWC verified various denominations of U.S. currency found in Joseph's possession both on his person and in various locations in the vehicle. Deputy 2 documented in the crime report, *"Jovannie was in possession of a large sum of money in the following denominations: 26 $1 bills ($26), 8 $2 bills ($16), 1 $5 bill ($5), 3 $10 bills ($30), 1 $20 bill ($20), 44 $50 bills ($2200), and 29 $100 bills ($2900) for a total of $5,197…"* The counting of the cash was captured by Deputy 2's BWC, on both audio and video. The cash was itemized by denomination in the presence of Deputy 4 while they were still on scene of the traffic stop. The BWC verified the totals documented in the report. Per the crime report, *"U.S. currency-Cash $5197.00"* was impounded on Evidence Tag S1014998. The investigation clearly established that the allegation is not true.

7. Misconduct/Procedure – Deputy 2 turned their Body Worn Camera (BWC) "on and off" during a traffic stop on 01-06-25.

   Board Finding: Unfounded
   Staff Recommended Finding: Unfounded
   Rationale: Complainant Jovannie Joseph alleged, *"And when he pulled me over he was turning his camera off and on."* See Rationale 1. BWC was reviewed. Deputy 2 conducted the traffic stop at approximately 1:38pm. Joseph was transported to a Sheriff's Station at approximately 3:30pm. Deputy 2's BWC video was activated before he exited his patrol car and remained on until after Joseph was driven to the nearest SDSO station by another deputy. Deputy 2's total BWC video time while on scene was over 3 hours and 30 minutes. There was no BWC video interruption. Per SDSO P&P 6.131 BWC: *The record mode of the camera should be activated prior to actual contact with a citizen (victim/witness/suspect), or as soon as safely possible, and continue recording until the contact is completed. Law enforcement related contacts include but are not limited to the following: traffic stops… 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… Here are considerations for muting:…Tactical Considerations…Confidential Information Considerations…Confidential Informant Considerations…* The investigation clearly established that the allegation is not true.

8. Misconduct/Procedure – Deputies 1-5 failed to comply with SDSO's Body Worn Camera BWC() policy.

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: Deputies 1, 2, 3, 4 and 5 muted their BWCs during their interactions on this incident and all failed to document the reason in writing. See Rationales 1 and 7. The deputies provided confidential statements that were taken into consideration for the recommended finding. Per SDSO P&P 6.131 Body Worn Cameras Muting:…*In all cases where BWC video is muted, it shall be documented in writing…*The investigation disclosed evidence sufficient to prove the allegation by a Preponderance of the Evidence.

AYE: 8
ABSENT: 3
NAY: 0
ABSTAIN: 0

25-077/CURTIS (Routine)

1. False Arrest – Deputy 1 arrested Jennifer Curtis on 02-26-25.

   Board Finding: Action Justified
   Staff Recommended Finding: Action Justified
   Rationale: Complainant Jennifer Curtis reported she was falsely arrested by deputies during a custody exchange with her ex-husband for violating a restraining order. The investigation reviewed the SDSO Crime/Incident Report, Body Worn Camera (BWC) footage, and the Restraining Order. The restraining order identified Curtis' ex-husband as the protected party and Jennifer Curtis as the restrained party and was in effect through 09-18-25. The Order prohibited harassment, disturbing the peace, and contact with the protected party, with a limited exception for brief and peaceful communication related to child exchanges. On 02-26-25, deputies responded to a call for

service regarding a reported restraining order violation. The reporting party stated that Curtis refused to release their child and attempted to open his vehicle door. BWC footage showed deputies contacting both parties and reviewing cell phone video recordings provided by Curtis. The recordings, as observed on BWC, showed Curtis approaching the reporting party at close proximity, continuing verbal engagement after being directed to use a court-ordered communication application, and following him as he moved within the parking lot. The footage also showed Curtis holding a child during the exchange while the reporting party requested that the child be returned as they attempted to maintain distance. Additional footage captured Curtis approaching the reporting party's vehicle and attempting to access the door while being told not to enter the vehicle. The exchange lasted over thirty minutes, and deputies ultimately facilitated the return of the child to the reporting party. California Penal Code section 273.6(a) states: *"Any intentional and knowing violation of a protective order, as defined in Section 6218 of the Family Code, or of an order issued pursuant to Section 527.6, 527.8, or 527.85 of the Code of Civil Procedure, or Section 15657.03 of the Welfare and Institutions Code, is a misdemeanor punishable by a fine of not more than one thousand dollars ($1,000), or by imprisonment in a county jail for not more than one year, or by both that fine and imprisonment."* SDSO Policy Section 2.51, Arrest, Search and Seizure, states: "*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."* SDSO Policy Section 6.55, Protective Orders, states: *"Personnel will thoroughly investigate reports of violations of court issued protective orders concerning domestic violence or other civil or criminal disturbances. Emphasis will be placed on strict enforcement of these laws to ensure the victim's safety as well as compliance with the law."* The investigation showed the alleged act did occur but was lawful, justified, and proper.

2. Misconduct/Procedure – Deputy 1 failed to document a reason for muting their Body Worn Camera (BWC) on 02-26-25.

   <u>Board Finding</u>: Sustained
   <u>Staff Recommended Finding</u>: Sustained
   <u>Rationale</u>: Refer to Rationale 1. BWC footage showed, Deputy 1 stated, *"Can you go blue for tac comms,"* prior to muting the audio on the BWC and the audio remained muted while Deputy 1 engaged in communication with another deputy on scene. The BWC audio was later reactivated, and the investigation continued. While the muting of the BWC was preceded by a verbal statement referencing tactical communications; the Crime/Incident Report did not detail the circumstances or justification for disabling the audio recording as required per policy. SDSO P&P 6.131, Body Worn Camera, stated, *"The body-worn camera (BWC) is an "on-the-body" audio and video recording system assigned to a deputy sheriff or community services officer (CSO) as an additional means of documenting specific incidents in the field Law Enforcement Services Bureau (LESB), Court Services Bureau (CSB), and Detention Services Bureau (DSB). Deputies/ CSO's are responsible for knowing and complying with this procedure and applicable bureau specific manuals and procedures… 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: 8
ABSENT: 3
NAY: 0
ABSTAIN: 0

<u>25-079/ZAYAK</u> (Summary Dismissal)

1. Illegal Search & Seizure – Unidentified deputies towed Zayak's vehicle.

   <u>Board Finding</u>: Summary Dismissal
   <u>Staff Recommended Finding</u>: Summary Dismissal
   <u>Rationale</u>: Complainant John Zayak complained his vehicle was towed from an unidentified location in the city of Fallbrook for the registration being expired over six months. Zayak further complained he was unable to schedule a "*tow hearing*" with unidentified SDSO personnel. 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: 8
ABSENT: 3
NAY: 0
ABSTAIN: 0

25-084/VAVRU (GBI)

1. Use of Force Resulting in Great Bodily Injury – Deputies Christian Del Angel, Darryl Patmon, Gabriel Sanvictores, and Michael Smith utilized force on Frank Vavru on 06-24-25.

   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 06-24-25, SDSO deputies responded to assist Barona Tribal Enforcement (BTE) Officers after Frank Vavru threw a metal rebar pole at them, attempted to steal a marked BTE Patrol Vehicle, and ultimately barricaded himself inside of it. Deputies determined there was probable cause to arrest Vavru for assault with a deadly weapon and attempted theft of a vehicle. Deputies issued numerous verbal commands to Vavru who refused to comply and exit the vehicle. Vavru responded to the verbal commands by striking the interior of the vehicle with his fists and refusing to drop a *"shiny object"* in his hand. Following 40 minutes of unsuccessful negotiation attempts, Deputy Sanvictores deployed a less lethal projectile at the rear window of the BTE vehicle. Once the vehicle's window was shattered, Deputy Patmon deployed pepper ball rounds containing Oleoresin Capsicum (OC) powder. The chemical agent in the pepper balls saturated the vehicle's interior. Vavru responded to the irritant by refusing to exit the vehicle, covering his face with a cloth, and repeatedly striking the interior of the vehicle with his fists. K-9 Deputy Smith issued verbal commands to Vavru ordering him to exit the vehicle, Vavru refused to comply. K-9 Deputy Smith deployed his K-9 partner into the vehicle. The K-9-bit Vavru's right arm resulting in an injury. Following the K-9 bite, Deputies Del Angel and Smith pulled Vavru out of the vehicle and placed him into custody. Vavru received medical attention on scene and was ultimately transported to the hospital for further medical treatment. SDSO P&P Section 11.20: "*Less Lethal Impact Munitions are projectiles used as intermediate force options against subjects exhibiting assaultive or life-threatening behavior. They are less likely to result in serious bodily injury or death and can be a resource to de-escalate a potentially deadly situation. Approved Less Lethal Munitions include: 12-gauge bean bag munitions, Irritant-filled projectiles, 40mm Impact Munitions, Rubber Ball Grenades."* SDSO P&P Section 11.17: "*(a) Chemical Agents are intermediate force options that can be used to overcome active resistance. (b)Deputies must be trained prior to using a specific chemical agent or device. Approved chemical agents include: Oleoresin Capsicum (OC) aerosol spray; Irritant filled projectiles (for area saturation), and other chemical agents used for crowd control or barricaded subjects."* SDSO P&P Section 11.9, Types of Resistance stated: "*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)".* Per SDSO K-9 Unit Manual Section 4.4: "*A canine may be used to locate and apprehend a suspect if the canine handler reasonably believes that the individual has either committed, is committing, or threatening to commit any serious offense and if any of the following conditions exist: (a) There is a reasonable belief the suspect poses an imminent threat of violence or serious harm to the public, any deputy/officer, or the handler. (b) The suspect is actively resisting or threatening to resist arrest and the use of a canine reasonably appears to be necessary to overcome such resistance. (c) The suspect is believed to be concealed in an area where entry by anyone other than the canine would pose a threat to the safety of deputies/officers or the public."* The investigation showed the alleged act did occur but was lawful, justified, and proper.

2. Misconduct/Procedure– Deputy 2 muted their Body Worn Camera (BWC) during the investigation.

   Board Finding: Action Justified

Staff Recommended Finding: Action Justified
Rationale: Refer to Rationale 1. Deputy 2 interviewed Vavru at the hospital regarding the canine contact, during which he muted his BWC for approximately four minutes. Deputy 2 documented the reason for muting his BWC in a Deputy Report which was permitted under SDSO's current BWC Policy. Confidential statements were considered. 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 and Confidential Information 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 showed the alleged act did occur but was lawful, justified, and proper.

AYE: 8
ABSENT: 3
NAY: 0
ABSTAIN: 0

25-101/GRIFFITH (Routine)

1. Misconduct/Truthfulness – Unidentified Probation Officer (PO) provided inaccurate information during a Court proceeding on 08-20-25.

Board Finding: Not Sustained
Staff Recommended Finding: Not Sustained
Rationale: On 09-04-25, CLERB received a signed complaint from Kratina Griffith, which alleged an unidentified Probation Officer (PO) provided inaccurate information during a Court proceeding on 08-20-25. Griffith alleged, at the Court Hearing, a PO did not report to the Court that the defendant has unpaid restitution. Griffith alleged the defendant was ordered to pay victim restitution as a condition of their Probation. For CLERB to access an individual's associated Probation reports and records, an authorization form agreeing to the disclosure must be signed by the individual currently serving, or who has previously completed, the grant of probation. CLERB is not entitled to receive records in this case. It should be noted, an individual who has completed a grant of probation, and who has an unsatisfied restitution order, is not indicative of any misconduct or that the individual on probation has violated an Order of the Court. CA Penal Code (PC), Section 1202.4, Victim Restitution, stated, "*(l) In every case in which the defendant is granted probation, the court shall make the payment of restitution fines and orders imposed pursuant to this section a condition of probation. Any portion of a restitution order that remains unsatisfied after a defendant is no longer on probation shall continue to be enforceable by a victim pursuant to Section 1214 until the obligation is satisfied."* PC Section 1214, Enforcement of Payment of Fine – "*A victim shall have access to all resources available under the law to enforce the restitution order, including, but not limited to, access to the defendant's financial records, use of wage garnishment and lien procedures, information regarding the defendant's assets, and the ability to apply for restitution from any fund established for the purpose of compensating victims in civil cases. Any portion of a restitution order that remains unsatisfied after a defendant is no longer on probation, parole, postrelease community supervision under Section 3451, or mandatory supervision imposed pursuant to subparagraph (B) of paragraph (5) of subdivision (h) of Section 1170 or after a term in custody pursuant to subparagraph (A) of paragraph (5) of subdivision (h) of Section 1170 is enforceable by the victim pursuant to this section. Victims and the California Victim Compensation Board shall inform the court whenever an order to pay restitution is satisfied. A local collection program may continue to enforce victim restitution orders once a defendant is no longer on probation, postrelease community supervision, or mandatory supervision or after completion of a term in custody pursuant to subparagraph (A) of paragraph (5) of subdivision (h) of Section 1170."* The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

AYE: 8
ABSENT: 3
NAY: 0
ABSTAIN: 0

25-134/NARVAEZ (Routine)

1. Misconduct/Procedure – Deputy 1 failed to provide medical care to an Incarcerated Person (IP) on 11-06-25.

   Board Finding: Unfounded
   Staff Recommended Finding: Unfounded
   Rationale: Complainant Michelle Narvaez, reported on 11-06-25, the aggrieved was arrested and booked into the San Diego Central Jail (SDCJ). The IP was placed into a holding cell, fell asleep and fell off the bench and was injured. The complainant believed Deputy 1 did not provide medical care to the aggrieved. Narvaez claimed the deputy told the IP, *"You better not be fucken lying to me about falling (off the bench)."* BWC was reviewed and the statement was not heard. BWC showed Deputy 1 conducted a brief investigation into the aggrieved claiming that he fell, and it confirmed the IP did fall and was not assaulted by another IP. On 11-07-25, jail medical records and BWC confirmed that Deputy 1 requested medical attention for the aggrieved, and he was seen by a nurse for his injuries from the fall. Medical records indicated that the IP was also seen by a medical provider for his injuries on this same day. Per DSB P&P Section M.1, Access to Care, *"Any incarcerated person in the custody of the San Diego Sheriff shall have quality and timely access to care for their medical, dental and mental health needs. The Responsible Health Authority (RHA) shall identify and eliminate any unreasonable barriers, intentional or unintentional, to inmates receiving health care."* The investigation clearly established that the allegation is not true.

2. Misconduct/Discourtesy – Deputy 2 was "*unprofessional and inconsiderate*" to an IP on 11-13-25.

   Board Finding: Unfounded
   Staff Recommended Finding: Unfounded
   Rationale: Complainant Michelle Narvaez alleged that Deputy 2 told the aggrieved to "*Stop calling his sister and causing a scene and acting like he is dying."* This comment was made after Narvaez talked to the aggrieved on the phone and believed the comment to be *"unprofessional and inconsiderate."* On 11-13-25, Narvaez spoke to a supervisor at the jail. Narvaez informed them the aggrieved was in pain from a fall and she was concerned his injury was getting worse and he needed emergent care. After this phone call, Deputy 2 spoke to the aggrieved about his injury for 2 minutes and 45 seconds. Per BWC, during their discussion, Deputy 2 learned the IP was concerned he might have refractured his arm when he fell and he believed he needed a higher level of care. Deputy 2 told the aggrieved he would take him to see a nurse but there was only one on duty at the time. Per BWC, Deputy 2 stated, *"So if you're on the phone with her dude, don't fucking scare her, we take that shit serious", and "Just don't scare your sister dude because she was really worried on the phone."* Per DSB 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.*" Jail medical records indicated the aggrieved was taken to the nurse that evening and seen by a medical provider the following morning in accordance with DSB P&P Section M.1, Access to Care. The investigation clearly established that the allegation is not true

AYE: 8
ABSENT: 3
NAY: 0
ABSTAIN: 0

25-156/GOLU (Summary Dismissal)

1. Criminal Conduct – Deputy 1 assisted Dorian Golu's neighbors with their *"drug operation."*

   Board Finding: Summary Dismissal
   Staff Recommended Finding: Summary Dismissal
   Rationale: Complainant Dorian Golu called SDSO dispatch on 09-12-25, reference *"neighbors using gas/skunk smell against him*," but he was unsure if he wanted deputies to respond, in fear of being *"illegally arrested*" again.

Golu asked a Communications supervisor to call him back before he decided if he wanted deputies to respond. Deputy1 was the Comm Center supervisor working at the time of Golu's call. After that conversation, Golu alleged Deputy 1 would not help him because he was *"helping drug dealers* (neighbors)." Golu further alleged that Deputy 1 was one of the *"officers"* that had him arrested in July 2025. CLERB case 25-091 was an investigation into the *"Illegal arrest"* claim and the arrest of Golu was deemed "Action Justified" by the Review Board. Deputy 1 was not a subject officer in that investigation nor was he mentioned. CLERB has reviewed two prior cases (24-125 and 25-091) and all allegations in the current complaint were investigated. Golu presented no new evidence to support his complaint. Per CLERB's Purpose, Section 1.2, Purpose, CLERB shall also make every effort to ensure public awareness of the seriousness of the process, and that fabricated complaints will neither be tolerated nor reviewed. Pursuant to CLERB Rules and Regulations, Section 15, Summary Dismissal, CLERB investigators determined the complaint is so clearly without merit that no reasonable person could sustain a finding based on the facts.

AYE: 8
ABSENT: 3
NAY: 0
ABSTAIN: 0

25-157/HOULE (Summary Dismissal)

1. Misconduct/Medical – Medical staff *"under medicated*" and failed to respond to IP Travis Houle's request for additional medication in June to August 2024 and in "2025".

   Board Finding: Summary Dismissal
   Staff Recommended Finding: Summary Dismissal
   Rationale: IP Houle alleged while incarcerated, he was "*under medicated"* by medical staff who also *"ignored hundreds of medical request forms"* for pain medication. Houle considered these acts to be *"torture."* Per CLERB Rules and Regulations Section 4.1, Complaints: 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 alleged misconduct involved SDSO medical staff, therefore the Review Board lacks jurisdiction.

2. Misconduct/Procedure – Unidentified deputies failed to respond to IP Houle's intercom requests in "2025".

   Board Finding: Summary Dismissal
   Staff Recommended Finding: Summary Dismissal
   Rational: IP Houle reported while incarcerated, deputies, "*Omitted bringing me to the Medical Department after hitting the emergency medical button for hours"* in the year *"2025*". Houle only provided a timeframe of 06-24 to 08-24 and the year 2025, where he alleged unknown deputies did not respond to his intercom requests. After multiple requests for specified information, Houle failed to provide needed information to investigate. Per CLERB R&R Section 15, Summary Dismissal: "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." The lack of cooperation by the Complainant is such that CLERB was unable to continue its investigation and the Review Board lacks jurisdiction.

3. Misconduct/Procedure – Unidentified deputies failed to take medical requests from IP Houle in 2024 and 2025.

   Board Finding: Summary Dismissal
   Staff Recommended Finding: Summary Dismissal
   Rational: IP Houle reported while he was incarcerated, *"level 5 deputies negated medical reports via Deputy Walks and Deputy Interactions."* See Rationale 2. The lack of cooperation by the Complainant is such that CLERB was unable to continue its investigation and the Review Board lacks jurisdiction.

AYE: 8
ABSENT: 3
NAY: 0
ABSTAIN: 0

26-034/STRONG (Summary Dismissal)

1. Misconduct/Procedure – San Diego Police Officers disposed of Strong's personnel property on 12-15-25.

   Board Finding: Summary Dismissal
   Staff Recommended Finding: Summary Dismissal
   Rationale: Clifford Strong alleged San Diego Police Officers improperly discarded Strong's personal property after Strong was arrested. The complaint submitted to CLERB was forwarded to the Commission on Police Practices who has jurisdiction over members of the San Diego Police Department. Pursuant to CLERB Rules and Regulations, Section 15, Summary Dismissal, CLERB investigators determined CLERB does not have jurisdiction over the subject matter of the complaint.

AYE: 8
ABSENT: 3
NAY: 0
ABSTAIN: 0

Adjourned 11:59 pm ***End of Report***