County of San Diego

CITIZENS' LAW ENFORCEMENT REVIEW BOARD

1600 PACIFIC HIGHWAY, SUITE 077, SAN DIEGO, CA 92101
TELEPHONE: (619) 238-6776
www.sdcounty.ca.gov/clerb

SPECIAL MEETING AMENDED AGENDA

Thursday, Aug 6, 2026, 4:00 p.m.
County Administration Center
1600 Pacific Highway, Chamber Room 310, San Diego, 92101
(Free parking is available in the underground parking garage, on the south side of Ash Street, in the public parking spaces.)
-AND-
Zoom Platform
https://sdcounty-ca-gov.zoom.us/j/89139318308
Phone: +1 669 444 9171
Webinar ID: 891 3931 8303

Pursuant to Government Code Section 54954.2 the Citizens' Law Enforcement Review Board will conduct a meeting at the above time and place for the purpose of transacting or discussing business as identified on this agenda. Complainants, subject officers, representatives, or any member of the public wishing to address the Board should submit a "Request to Speak" form prior to the commencement of the meeting.

DISABLED ACCESS TO MEETING

A request for a disability-related modification or accommodation, including auxiliary aids or services, may be made by a person with a disability who requires a modification or accommodation in order to participate in the public meeting. Any such request must be made to CLERB at (619) 238-6776 at least 24 hours before the meeting.

WRITINGS DISTRIBUTED TO THE BOARD

Pursuant to Government Code Section 54957.5, written materials distributed to CLERB in connection with this agenda less than 72 hours before the meeting will be available to the public at the CLERB office located at 1600 Pacific Highway, Ste. 077, San Diego, CA 92101.

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

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

3) **PUBLIC COMMENTS (10 minutes)**

This is an opportunity for members of the public to address the Board on any subject matter that is within the Board's jurisdiction but not an item on today's open session agenda. **Each speaker shall complete and submit a "Request to Speak" form.** Each speaker will be limited to **two minutes**; however, the time allotted for in-person, virtual and written public comment may be adjusted by the Board Chair in their discretion. This meeting will also be held remotely via the Zoom Platform. Click the link in the agenda header above to access the meeting. Contact CLERB at clerb@sdcounty.ca.gov or 619-238-6776 if you have questions.

4) **CLOSED SESSION: TIME CERTAIN – 4:15 pm**

a) PUBLIC EMPLOYEE DISCIPLINE/DISMISSAL/RELEASE

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

25-075 BAGBY (Death)

1. Death Investigation/Detentions – Incarcerated Person (IP) Linda Bagby died while incarcerated at the Las Colinas Detention & Reentry Facility (LCDRF) on 06-13-25.

   Board Finding: Pending (Adopted/Deferred)
   Conclusion: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. Bagby was arrested by El Cajon Police on 01-03-25 and booked into jail. Bagby was classified as low level IP and placed into housing module 3E. During Bagby's approximate five months in custody, she was prescribed numerous medications for both physical and mental ailments. Additionally, Bagby submitted eleven health care requests which were addressed by medical staff and over thirty individual notations by medical staff were noted in Bagby's medical records. CCTV revealed Bagby was last seen outside of her cell picking up her medications at around 8:34pm on 06-12-25. The deputy entered the cell and woke Bagby who was audibly snoring. The deputy shook Bagby and asked, "*Linda are you good?*" Bagby moved her arms, shook her head and replied, "*I'm good*." SDSO DSB I.43 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.). Incarcerated persons away from the facility for authorized reasons (e.g., court, medical appointments, etc.) will be accounted for upon their return*." During lunch service Bagby failed to come out of her cell and an IP Inmate Worker delivered Bagby's meal to her cell at about 10:44am. Seven safety checks were conducted by deputies between lunch service and dinner service at about 4:15pm. SDSO DSB I.64 said, "*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.*" At about 4:26pm, Deputy 1 realized Bagby had not come out for her meal and noticed her cell door was open. Deputy 1 directed the IP Inmate Worker to deliver food to Bagby. The IP again entered Bagby's cell to deliver food, however she noticed Bagby's skin color was purple and screamed for help. Deputy 1 immediately responded to the cell, determined Bagby was not breathing, called for assistance and began CPR. Medical personnel including a facility doctor responded and continued lifesaving measures. Paramedics arrived and after continued lifesaving measures pronounced Bagby deceased at about 4:34 pm. SDSO DSB M.5 said, "*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.*" Per the Medical Examiner's report, the cause of death was determined as, "*Complications of Dilated Cardiomyopathy*" with contributing factors of, "*Congestive Mild Hepatomegaly and splenomegaly; History of chronic alcoholism; Morbid Obesity.*" The manner of death was determined to be, "*Natural.*" Per CLERB Rules & Regulations 16.1, at the conclusion of a matter before the entire CLERB, CLERB shall deliberate and adopt a final report ("Final Report") with respect to the case or matter under consideration. This report shall include Findings as to the facts relating to any case, as well as an overall conclusion as to any case as specified in Section 16.2.

2. Misconduct/Procedure – Deputy 1 and unidentified deputies failed to perform proper safety checks.

   Board Finding: Pending
   Staff Recommended Finding: Unfounded
   Rationale: A complainant alleged unidentified deputies failed to perform proper safety checks in the hours leading up to Bagby's death. See Rationale 1. The investigation revealed that between 12:14am and 4:26pm on 06-13-25, deputies conducted 21 checks in Housing area 3 including meal service, safety checks, soft counts, and hard counts. SDSO DSB I.64 said, "*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." All the checks conducted were verified via CCTV footage. By a preponderance of the evidence, the investigation clearly established that the allegation is not true.

3. Misconduct/Procedure – Deputy 1 failed to identify medical distress.

   Board Finding: Pending
   Staff Recommended Finding: Unfounded
   Rationale: A complainant alleged, "T*owards the end of her life, Linda Bagby displayed signs of obvious medical distress which also went ignored by medical* (unidentified) *and correctional staff* (unidentified)*. It is believed Linda Bagby repeatedly asked for medical assistance and told correctional deputies* (unidentified) *that she needed medical assistance. Medical assistance was either not summoned or not provided.*" See Rationale 1. The last physical interaction between sworn staff and Bagby was on 06-13-25 at about 9:47am during a hard count. Deputy 1 arrived at Bagby's cell and knocked on the door. Bagby failed to answer prompting Deputy 1 to enter the cell. Upon entering the cell, Bagby was lying on her bed with her arms over her head and appeared to be sleeping. Loud snoring sounds could be heard coming from Bagby. Deputy 1 shook Bagby and asked, "*Linda are you good?*" Bagby moved her arms, shook her head and replied, "*I'm good*." Deputy 1 left the cell and continued with her check. SDSO DSB P&P I.43 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.). Incarcerated persons away from the facility for authorized reasons (e.g., court, medical appointments, etc.) will be accounted for upon their return*." By a preponderance of the evidence, the investigation clearly established that the allegation is not true.

4. Misconduct/Procedure –Deputy 1 failed to perform or summon emergency medical care.

   Board Finding: Pending
   Staff Recommended Finding: Unfounded
   Rationale: A complainant alleged unidentified deputies failed to perform and summon emergency medical care for Bagby. Per BWC, Bagby was found not breathing in her cell by Deputy 1 at about 4:28pm. Deputy 1 immediately notified a partner deputy, requested medical staff and the activation of 911. Deputies began CPR on Bagby and at 4:29pm medical staff took over CPR. The facility doctor was on scene at 4:30pm and directed Bagby to be moved outside of the cell, took over CPR, and initiated the application of an AED. Paramedics arrived at 4:34pm and assisted with medical aid until pronouncing Bagby deceased. SDSO DSB M.5 said, "*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.*" By a preponderance of the evidence, the investigation clearly established that the allegation is not true.

5. Death Investigation/Health Care Providers - Incarcerated Person (IP) Linda Bagby died while incarcerated at the Las Colinas Detention & Reentry Facility (LCDRF) on 06-13-25.

   Board Finding: Pending (Adopted/Deferred)
   Conclusion: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. See Rationale #1. Per the Medical Review Report, the care provided to Linda Bagby was within the standard of care for correctional facilities. There were a sufficient number of health staff of varying types available to provide adequate, timely evaluation and treatment utilizing contemporary standards of care. Medical staff provided a quick and appropriate response to Bagby's medical emergency. When IP Bagby requested to be seen by medical, she received adequate and timely treatment. SDSO MSD P&P S.3 Sick Call said, "*Patients shall be assessed, treated, and provided appropriate medical services for illness or injury on a daily basis*." SDSO MSD Section A.1.1 said, "*Inmates have access to care for their serious medical, dental, and mental health needs. Access to care means that,*

in a timely manner, a patient is seen by a qualified health care professional, is rendered a clinical judgment, and receives care that is ordered." When medical was notified that IP Bagby needed emergent care, a nurse and physician responded within three minutes, showing a variety of medical staff, and a quick and appropriate response. SDSO MSD Section M.1, Medical Emergencies said, "*A physician (MD) or Registered Nurse (RN) shall evaluate the medical emergency; provide Basic Life Support (BLS) and request appropriate transportation, when on duty. Security will not be compromised in any medical emergency. In the event of a critical incident, medical staff will, upon notification by sworn staff, respond and standby with emergency response equipment*." 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.

6. Misconduct/Health Care Providers - Medical staff denied repeated requests for medical care.

   Board Finding: Pending
   Expert Recommended Finding: Unfounded
   Rationale: The complaint alleged: "*Towards the end of her life, Linda Bagby displayed signs of obvious medical distress which also went ignored by medical* (unidentified) *and correctional staff* (unidentified)*. It is believed Linda Bagby repeatedly asked for medical assistance and told correctional deputies* (unidentified) *that she needed medical assistance. Medical assistance was either not summoned or not provided."* The complaint alleged medical staff denied repeated requests for medical care during her incarceration. See Rationales 1 and 5. Per the Medical Review Report, Bagby received adequate and timely care each time she requested medical assistance. The chart demonstrated that Bagby placed numerous nonemergency sick call requests and was seen within days of those requests. She was to be assessed for a nonemergency sick call within days of her death. The request was appropriately assessed and scheduled for sick call. When she was not available for the sick call due to a court appearance, she was rescheduled per policy. Bagby's sick call was reviewed and scheduled and then rescheduled per policy. SDSO MSD Section A.1.1 states, "*Inmates have access to care for their serious medical, dental, and mental health needs. Access to care means that, in a timely manner, a patient is seen by a qualified health care professional, is rendered a clinical judgment, and receives care that is ordered*." SDSO MSD.S.3 states "*Incarcerated persons have timely access to non-emergent healthcare*." The policy continues*, "Sick calls are scheduled as either priority or routine. Routine sick calls are scheduled within seven (7) days, while priority sick calls are scheduled within the timeframe appropriate to the severity of the complaint. All sick calls must be scheduled using the appropriate sick call encounter in the electronic health record.*" The policy also accounts for patients being out of the facility, "*When out of facility is selected, a reschedule date must be selected*." By a preponderance of the evidence, the investigation clearly established that the allegation is not true.

7. Misconduct/Health Care Providers – Medical staff failed to provide emergency medical care.

   Board Finding: Pending
   Expert Recommended Finding: Unfounded
   Rationale: The complaint alleged medical staff failed to provide emergency medical care. See Rationale 4. When Bagby was found in her cell unresponsive, CPR was initiated, the 911 system was activated and medical personnel to include and nurse and physician responded within three minutes of the notification. SDSO MSD M.1 said, "*A physician (MD) or Registered Nurse (RN) shall evaluate the medical emergency; provide Basic Life Support (BLS) and request appropriate transportation, when on duty. Security will not be compromised in any medical emergency. In the event of a critical incident, medical staff will, upon notification by sworn staff, respond and standby with emergency response equipment.*" By a preponderance of the evidence, the investigation clearly established that the allegation is not true.

25-103 CURREN (Death)

1. Death Investigation/Detentions – Incarcerated Person (IP) Steven Curren died while incarcerated at the San Diego Central Jail (SDCJ) on 08-30-25.

   Board Finding: Pending (Adopted/Deferred)

Conclusion: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 04-20-26, Curren's father also submitted a complaint regarding the medical intake process. See Allegation 6. Evidence showed, Curren was arrested by San Diego Police (SDPD) on 08-29-25 at approximately 8:15am for charges related to a stolen vehicle. Curren was booked into San Diego Central Jail (SDCJ) where he was classified as a Level 2 IP. Curren was housed in Module 4C, cell 4 on 08-30-25 at about 2:42am with two cellmates, both classified as Level 3. Curren entered the module and carried his mattress to cell 4. Curren's cellmates described him a confused, shaking and unable to climb onto the top bunk, prompting them to put his mattress on the ground. Per Body Worn Camera (BWC), at about 7:58am, deputies conducted a cell inspection/safety check of cell 4 confirming both the intercom and water were operating. During the inspection, Curren's cellmates told deputies Curren needed help. When deputies asked Curren what he needed help with, Curren was unable to articulate, ultimately saying, "*I don't know*." At the time of the conversation, Curren was alert but laying on top of his mattress on the floor. Deputies explained to Curren they could not help him if he did not tell them what he needed help with and told him he could speak with the nurse at medication pass. 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.*" At about 8:34am, Curren wandered around the module during dayroom before entering the shower while wearing his clothes. IP 2 described that Curren, "*went to the shower without his soap and all that stuff in his full uniform and hit the water like he was gonna shower fully clothed without his towel*" and said, "*that's why I thought he was off*." Per CCTV footage, IP 2 found Curren in the shower and directed him to stand in line for medication pass. At about 9:04am, one of Curren's cellmates was involved in an altercation with an unidentified IP during dayroom prompting Curren's cell to be locked down the remainder of the day. Safety checks were conducted within policy timelines with the final one occurring at about 2:48pm. Per statements from Curren's cellmates, shortly after the last safety check, Curren began choking and spitting. According to their statements, the cellmates activated the intercom in their cell however it was not answered. See Allegation 4. About thirty seconds after activating the intercom, Curren's face began turning blue prompting the cellmates to again use the intercom and pound on their cell door to request help from IP's who were in the dayroom. IPs in the dayroom retrieved Naloxone from within the module and began pounding on the module door to get deputies attention. According to the cellmates, they each performed CPR compressions while IPs outside the door counted for them. Per CCTV, deputies made entry into the module about one minute and 39 seconds after IP's were alerted to the medical emergency. Deputies made entry into the cell, observed Curren blue in the face and requested immediate medical assistance via radio. Deputies removed Curren from the cell and began lifesaving measures including CPR and administration of Naloxone. DSB P&P M.5, Medical Emergencies said, "*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*." Medical staff began arriving within one minute of the request and continued lifesaving measures including an AED. San Diego Fire Department personnel arrived at about 3:16pm, continued lifesaving measures, and transported Curren to Mercy Hospital where he was pronounced dead. Per the Medical Examiner's report, Curren "*died as a result of the complications of hypertensive cardiovascular disease in the setting of a hypoplastic right kidney*." Contributing factors to the death were, "*Asthma, chronic ethanol use and obesity*." The manner of death was, "*natural*." 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 – Deputies 1 and 2 failed to refer IP Curren to medical personnel.

Board Finding: Pending
Staff Recommended Finding: Unfounded
Rationale: The investigation revealed that Curren's cellmates told deputies he needed assistance during a cell inspection. On 08-30-26 around 7:58am, Deputies 1 and 2 conducted a cell inspection of IP Curren's cell. Per BWC footage, at the time of the inspection, Curren was laying on his mattress on the floor, IP 1 was sitting on a stool, and IP 2 was laying in the middle bunk. IP 1 told deputies Curren was shaking and having trouble moving. Deputy 1 asked Curren, "*Are you taking medication, do you need to see the nurse, what do*

you need?" Curren answered, "*No, im just uh god damn it."* Deputy 1 asked Curren three times in various ways if he needed help and what he needed help with. Curren was lying down with his hand behind his head, alert and looking around but did not answer. IP 2 relayed that Curren would only say, "*I don't know*" whenever he or IP 1 asked also. Deputy 1 replied, "*Ok so I'm not a medical professional if he doesn't know if he needs help so when the nurse comes here, you can voice your concerns*" and ended the cell inspection. DSB P&P I.64, Safety Checks said, "*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 M.15, Medical Emergencies said, *"Incarcerated persons in need of urgent medical attention shall be immediately referred to health staff*." At about 8:39am, Curren stood in line for medication pass and received two of his prescribed medications from medical staff. There was no evidence that Curren voiced concerns to medical staff during medication pass. The evidence shows that the alleged act or conduct did not occur.

3. Misconduct/Procedure – Deputies 1 and 2 failed to recognize a medical emergency during a safety check.

   Board Finding: Pending
   Staff Recommended Finding: Unfounded
   Rationale: Due to timing of Curren's medical emergency, the preceding safety check was specifically investigated to determine if applicable SDSO policies were followed. O 08-30-26, Deputies 1 and 2 conducted a safety check at about 2:48pm, approximately fifteen minutes before Curren suffered a medical emergency. Per CCTV and BWC footage, deputies did not note any issues within the cell. Per BWC, there appeared to be no emergency taking place and one of Curren's cellmates can be seen laying in his bunk. According to CCTV at about 3:06pm, unidentified IPs in the dayroom responded to Curren's cell. Per statements from Curren's cellmates, they summoned help by activating the intercom and by getting the attention of IPs in the dayroom when they noticed Curren turn blue and stop breathing. DSB P&P I.64, Safety Checks said, "*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.

4. Misconduct/Procedure – Deputy 3 failed to answer an intercom call.

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained
   Rationale: The investigation revealed Curren's cellmates said they never received a response after requesting assistance via intercom. IP 2 said Curren had been coughing throughout the day, describing it as a "*dry cough*. "Shortly before the medical emergency IP 2 gave Curren water at his request. After getting the water, Curren began coughing again in a fashion IP 2 described as "*phlegmy*," "*thick*," and "*like he had something in his throat*." IP 2 said Curren was not covering his mouth and they were concerned he might throw up and spread germs in their cell. IP 2 said they told Curren to cover his mouth and he replied, "*I feel like I'm choking, I feel like I'm choking*." IP 2 said they, "*had enough of him*" so they pressed the intercom and requested someone get Curren out of their cell but never received an answer. Both IP 1 and IP 2 said Curren had spilled his water again. The IP's had described several previous instances of Curren spilling water. IP 2 said they noticed, "*He started turning blue and like I saw his eyes like shut so it wasn't like he was being sloppy and spilled it this time, he was like out*." Both cellmates described activating the intercom but never receiving a response prompting them to get the attention of IP's in the dayroom and requesting help. According to SDSO records, Deputy 3 was assigned to the control station. DSB P&P I.2 Intercom Systems said, "*Intercoms are generally located in areas accessible by incarcerated persons (e.g., dayrooms, cells, classrooms, etc.). Each facility shall maintain an inmate intercom system for the purpose of providing a means of communication between sworn staff and incarcerated persons. Intercom systems should be primarily used as a means of relaying and or summoning emergency assistance. Intercoms shall not be routinely muted or silenced*." SDCJ Green Sheet L.2.C.1 Sanitation & Hygiene Inspections said, "*Each week during hygiene inspection, deputies on floors 1 through 8 shall perform a check of all intercoms on their*

respective floors to ensure the intercoms are functioning, cleared of obstructions, and confirmed with control that the intercom is in working order." Per BWC, the intercom was checked and functioning earlier in the day. Deputy 3 provided a confidential statement during CLERB's investigation that was taken into consideration. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

5. Death Investigation/Health Care Providers – Incarcerated Person (IP) Steven Curren died while incarcerated at the San Diego Central Jail (SDCJ) on 08-30-25

   Board Finding: (Adopted/Deferred)
   Conclusion: This case was reviewed in accordance with CLERB Rules & Regulations 4.3.a, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. See Rationale 1. Per the Medical Review Report, there were no deviations from the established standards of care identified in the evidence reviewed. The staffing level for medical personnel was appropriate to the size of San Diego Central Jail (SDCJ). SDSO MSD Number A.3.1 Medical Autonomy said, "*Health care decisions are made by qualified health care professionals for clinical purposes. Ultimately, the qualified health provider is responsible for the appropriate management of the patient*.". The medical response to Curren's emergency was rapid and the lifesaving actions taken were appropriate. DSB P&P M.5, Medical Emergencies said, "*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*." 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.

6. Misconduct/Health Care Providers – Medical staff failed to conduct a thorough evaluation of Curren at intake.

   Board Finding: Pending
   Expert Recommended Finding: Unfounded
   Rationale: The complainant reported medical staff failed to conduct a thorough evaluation of Curren at intake. See Rationale 1. Per the Medical Review Report, the medical intake process was performed in a timely manner with the necessary relevant information captured. Curren appeared stable upon initial screening and was noted as having a history of asthma and depression. Curren's vital signs were within normal limits, and no suicidal ideations were presented. No evidence that would have alerted medical staff to the need for special placement or for more urgent evaluation was noted. SDSO MSD P&P E.2.1 Medical Clearance said, "*a documented clinical assessment of medical, dental, and mental status before an individual is admitted into the facility. The medical clearance may come from on-site health staff or may require sending the individual to the hospital emergency department (ED). Receiving Screening – A process of structured inquiry and observation intended to identify potential emergency situations among new arrivals and to ensure that patients with known illnesses and those on medications are identified for further assessment and continued treatment. Medication-Assisted Treatment (MAT) – the use of medications in combination with counseling and behavioral therapies to provide a "whole patient" approach to the treatment of substance use disorders*." The investigation clearly established that the allegation is not true.

24-144 DOE 2412 (GBI)

Final findings to be released upon approval of the Juvenile Court.

25-047 DOE 2502 (GBI)

Final findings to be released upon approval of the Juvenile Court.

End of Report