EXECUTIVE OFFICER
BRETT KALINA

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

The Citizens' Law Enforcement Review Board made the following findings in the Special Meeting closed session portion of its **August 6, 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 lacks merit.

CASES FOR SUMMARY HEARING (2)

ATTENDANCE: Eight (Pintar, Mendleson, Bisson, Brown, Dumas, Fasano, Mondragon, Moody)

ALLEGATIONS, BOARD FINDINGS & RATIONALES

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: Adopted
   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: Unfounded
   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: Unfounded
   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: Unfounded
   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: Adopted
   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: Unfounded
   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: Unfounded
   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.

***AYE:* 7**
***NAY:* 1 (Thomas)**

25-103/CURREN (Death)
DEFERRED
***AYE:* 8**
***NAY:* 0**

Adjourned 5:25 pm ***End of Report***