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

REGULAR MEETING AGENDA
Thursday, Aug 6, 2026, 5:30 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/89264487063
Phone: +1 669 444 9171
Webinar ID: 892 6448 7063

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 (1 minute)

3) PUBLIC COMMENTS (45 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) MINUTES APPROVAL (2 minutes)

a) Draft Meeting Minutes for June 4, 2026 (Attachment A)

5) **PRESENTATION/TRAINING** (**0 minutes**)

a) None

6) **EXECUTIVE OFFICER'S REPORT (10 minutes)**

a) Overview of Activities of Executive Officer

b) Workload/Status Report (Attachment B)

c) Outreach Report (Attachment C)

7) **BOARD CHAIR'S REPORT (5 minutes)**

8) **BOARD MEMBER QUERY for SHERIFF/PROBATION LIAISON(S) (10 minutes)**

9) **NEW BUSINESS (20 minutes)**

a) Approval of Revised Rules and Regulations (Attachments D & E)

b) Approval of Additions to Board Member Procedural Manual (Attachments F & G)

10) **UNFINISHED BUSINESS (0 minutes)**

a) None

11) **BOARD MEMBER COMMENTS (15 minutes)**

12) **CLOSED SESSION: TIME CERTAIN – 7:30 pm**

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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).

CASES FOR SUMMARY HEARING (23)

Notice: The Citizens Law Enforcement Review Board (CLERB) may take any action with respect to the items included on this agenda. Recommendations made by staff do not limit actions that the CLERB may take. Members of the public should not rely upon the recommendations in the agenda as determinative of the action the CLERB may take on a particular matter.

24-073/TANNER (Death)

1. Death Investigation – Randal Kelly Tanner died on 02-12-23, following a use of force incident that occurred in 2019.

   Board Finding: Pending (Adopted/Deferred)
   Conclusion: This case was reviewed pursuant to CLERB Rules and Regulations Section 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. Following notification by the Medical Examiner's Officer that Randal Tanner died on 02-12-23, SDSO initiated a homicide investigation to evaluate whether a nexus existed between Tanner's death and a use-of-force incident that occurred on 05-31-19. Following the 05-31-19 incident, CLERB opened Case #19-095/Tanner to investigate allegations, including excessive force, filed by Tanner and his encounter with deputies. On 09-08-20, the Review Board deliberated and found Unfounded for the allegation of excessive force involving Deputy 2, and Action Justified regarding Deputy 1's use of force. Following Tanner's death, CLERB reviewed BWC footage, paramedic records, jail medical records, autopsy findings, SDSO investigative records, and the complete investigative file from Case #19-095/Tanner. The Medical Examiner concluded: *"Based on the autopsy findings and the circumstances surrounding the death, as currently understood, the cause of death is small bowel ischemia and necrosis due to complications of chronic immobilization (quadriplegia) and debilitated state due to remote blunt force injuries of head and neck, with atherosclerotic and hypertensive cardiovascular disease and diabetes mellitus type 2 listed as contributing, and the manner of death is homicide."* The homicide investigation and the Medical Examiner's findings addressed the medical cause and manner of Tanner's death. The Medical Examiner's Report was the only new evidence presented and there is no reasonable likelihood the new evidence will alter the prior findings. The subject deputies are no longer employed by the Sheriff's Office. Pursuant to CLERB Rules and Regulations 16.1, at the conclusion of a matter before the entire CLERB, the Board shall deliberate and adopt a final report with findings of fact and an overall conclusion…"

24-095/MITCHELL (Death)

1. Death Investigation/Detentions – Chase Edward Mitchell died while in the custody of the San Diego Sheriff's Office on 07-15-24.

   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 06-13-24, Chase Mitchell was arrested by the Oceanside Police Department and subsequently booked into the custody of the San Diego Sheriff's Office (SDSO). Mitchell received an initial medical clearance and was determined fit to continue the booking process, at Vista Detention Facility (VDF). Mitchell was initially classified, pursuant to SDSO Detentions Services Bureau (DSB) P&P Section R.1, Incarcerated Person Classification, as "*Level 4*" and placed in "*general population housing.*" On 07-13-24, deputies observed Mitchell naked in his cell. It was noted Mitchell "*appeared to be dazed, confused and when I assisted in putting his shirt on, his skin was clammy. Mitchell also needed assistance being escorted down the stairs.*" Mitchell was escorted to Medical via a wheelchair. Mitchell was placed in "*Medical Ward 2*" for further observation. Medical staff conducted an evaluation of

Mitchell and it was noted that Mitchell self-reported weight loss. Medical staff determined to conduct weekly evaluations to monitor Mitchell's health. On 07-14-14, at approximately 7:30am, nursing staff advised deputies that Mitchell was "*having trouble breathing."* Mitchell was assessed by medical staff, provided treatment, and was deemed to remain in medical housing. At approximately 9:14am, deputies observed Mitchell "*shaky… grunting of pain, and loud breathing.*" Deputies acted pursuant to SDSO Detention Services Bureau (DSB) P&P, Section M.5, Medical Emergencies, which stated, "*All facility staff shall be responsible for taking appropriate action in recognizing, reporting or responding to an incarcerated person's emergency medical needs. In any situation requiring medical response, emergency medical care shall be provided with efficiency and speed without compromising security…*" Medical staff determined Mitchell would be transferred to Tri-City Medical Center for further care. Per SDSO DSB Section I.64, Safety Checks: Housing and Holding Areas of Incarcerated Persons, 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. Safety checks shall be conducted at least once within every 60-minute time period. Safety checks of Medical Observation Beds (MOB) and in Psychiatric Stabilization Units (WPSU/PSU) shall be conducted at least once within every 30-minute time period. The intervals of the safety checks, within the 60 or 30 minute time period, shall vary and must be logged in the Jail Information Management System (JIMS).*" A review of the safety checks of Mitchell while housed at VDF was documented in accordance with policy. While hospitalized, Mitchell's health condition continued to decline, and on 07-15-24, Mithcell was pronounced deceased by medical staff. Per the San Diego Medical Examiner's Report, the cause of death was, "*complications streptococcus pyogenes soft tissue infection, including necrotizing fasciitis.*" "*Hypertensive and atherosclerotic cardiovascular disease; pulmonary emphysematous changes,*" was listed as contributing. 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.

24-135/DOE 2403 (GBI)
Final findings to be released upon approval of the Juvenile Court.

24-156/DOE 2424 (GBI)
Final findings to be released upon approval of the Juvenile Court.

25-002/DUCKETT (Death)

1. Death Investigation/Detentions – Incarcerated Person Donell Duckett died while in SDSO custody on 01-10-25.

   Board Finding: Pending (Adopted/Deferred)
   Conclusion: This case was reviewed in accordance with CLERB Rules & Regulations, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 07-08-24, 67-year-old Donell Duckett was arrested by SDPD for narcotics related charges and booked into San Diego Central Jail (SDCJ). At the time of his arrest Duckett was undergoing treatment for a preexisting health concern requiring dialysis. During his incarceration at SDCJ, Duckett was placed in medical housing and received consistent dialysis treatment. Since August 2024, Duckett was assigned to the Medical Observation Unit where he remained until his passing. On 01-10-25, around 1:09am, medical staff recognized Duckett was in medical distress and rendered emergency care. SDSO deputies responded and assisted medical staff in transporting Duckett to the sallyport where they met with medics. Emergency medical treatment continued. Duckett was transferred to a hospital by ambulance where he was declared dead. The Medical Examiner's Office determined the cause of death was, "*Hypertensive and atherosclerotic cardiovascular and cerebrovascular disease with contributing factor of end stage renal disease,"* and the manner "*Natural."* A review of CCTV and SDSO records verified safety checks were conducted in accordance with policy. 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.

25-056/LINES (Death)

1. Death Investigation/Detentions – Incarcerated Person (IP) Callen Marie Lines died while in custody at Las Colinas Detention and Reentry Facility (LCDRF) on 05-12-25.

   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 05-11-25, IP Lines was booked into LCDRF by the El Cajon Police Department for arrest warrants. During the Intake process, IP Lines admitted to using Fentanyl daily with her last use at 9:00am the morning of her arrest. A urine test returned positive results for Methamphetamine, Amphetamine, Marijuana, Fentanyl, and Ecstasy. IP Lines was admitted into LCDRF and scheduled for a second stage nurse evaluation where she was provided a Medication Administration Plan. On 05-12-25, Lines was classified as a Level 2 offender and was housed with a cellmate. Evidence showed deputies conducted all safety checks within the required timeframes. Body Worn Camera (BWC) footage showed that IP Lines neither requested medical assistance nor reported any medical emergencies to deputies during safety checks and counts. At 5:31pm, Deputies 2 and 3 completed the last safety check before shift change. Both deputies had their BWC's activated. Deputy 3's BWC footage confirmed he approached IP Lines' cell and looked into the window. There were no audible indications that anyone was in medical distress. At 6:36pm, Deputy 1 completed a Soft Count within the required timeframe. BWC footage confirmed that when Deputy 1 passed by IP Lines' cell, there were no audible signs or indications that anyone inside needed assistance. Deputy 1 recalled seeing IP Lines and her cellmate alive and breathing in their respective beds. At approximately 6:50pm, Deputy 1 had additional contact with IP Lines via the cell intercom; see Rationale 2. At approximately 7:24pm, two Sergeants began a Supervisor Walk. One of the Sergeants approached Lines' cell, and saw Lines seated sideways on a chair with her feet facing the door and her torso bent backwards over the side of the chair facing away from the door. The Sergeant knocked on the cell door, and when there was no response, he opened the cell and immediately noticed IP Lines was in medical distress. Sworn staff began lifesaving measures to include CPR (Cardiopulmonary Resuscitation), administering Naloxone, and administering breaths using an Ambu Bag (Artificial Manual Breathing Unit). At approximately 7:28pm, medical staff arrived and continued lifesaving measures to include CPR, administering additional doses of Naloxone, and utilizing an AED (Automated External Defibrillator). At approximately 7:34pm, the Santee Fire Department and paramedics arrived and transported IP Lines to the hospital where she was pronounced dead at 8:13pm. The cellmate recalled seeing IP Lines repeatedly pressing the intercom and recalled deputies responding each time. The cellmate noted that IP Lines told an unidentified deputy she was having a seizure and the deputy responded, "*How could you be having a seizure if you're talking to me".* Following a search of the module and the IP's housed in the module, deputies discovered an IP that had been booked into LCDRF on 05-12-25 was found to be in possession of Methamphetamine and Fentanyl. The IP was housed in a cell directly next to IP Lines cell. The IP admitted she had smuggled the narcotics into LCDRF. The IP denied supplying narcotics to IP Lines and indicated she only provided them to her cellmate. There was no corroborating evidence to confirm if IP Lines had obtained any narcotics from this IP. Per statements from IP's housed within the module, several recalled that throughout the day IP Lines requested medical attention, made statements about her bail status, and asked other IP's for Fentanyl. The Medical Examiner's Report listed IP Lines cause of death as "*accidental"* and due to "*fentanyl and methamphetamine toxicity*. Per DSB P&P Section I.43, Count Procedures of Incarcerated Persons: "*All counts require sworn staff to verify each incarcerated person's well-being through "verbal or physical acknowledgment" from the incarcerated person. In addition, sworn staff will look for any obvious signs of medical or physical distress (e.g., asthma attack, chest pain, etc.), trauma (e.g., bleeding, ligature marks, etc.) and/or criminal activity (e.g., drug usage, fighting, etc.). Incarcerated persons away from the facility for authorized reasons (e.g., court, medical appointments, etc.) will be accounted for upon their return*." Per DSB P&P section I.64, Safety Checks: "*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*." Per CLERB Rules and Regulations 16.1, at the conclusion of this 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 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 – Deputies 1-3 failed to recognize IP Lines' need for medical attention.

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained
   Rationale: See Rationale 1. On 05-12-25, at 1:12pm, Deputy 2 was assisting with medication distribution at a neighboring cell when IP Lines was heard saying, "*Please. Please. Help get me out of here."* Deputy 2 and a Registered Nurse (RN) immediately entered the cell and IP Lines mumbled she needed a shower and was having a seizure followed by repeated requests to use the phone for bail. IP Lines stated several times she felt like she was going to have a seizure. The RN took IP Lines' vital signs and provided her with medication and cleared her to remain in the cell. Evidence showed throughout the day, deputies had several interactions with IP Lines during which IP Lines did not indicate any medical concerns that went unaddressed. The majority of deputy contact with IP Lines consisted of her requesting a phone to contact the bail company. Per Deputy 1, IP Lines activated the cell's intercom one time after the Soft Count at 6:50pm and requested a shower. Deputy 1 responded to the intercom activation and denied IP Lines request due to module scheduling. The denied request was in accordance with DSB P&P Section I.63, Facility Security Housing Units, Subsection III: "*Dayroom will be offered to one tier at a time. The hours in which dayroom should be open and accessible are 0700-1000 hours, 1300-1600 hours, and 1900-2200 hours. The doors leading to the connecting hallway in House 3 shall remain closed while incarcerated persons are in the dayroom. Assigned incarcerated person module workers will only be permitted to be out of their cells outside of dayroom hours to clean and distribute meals."* Per DSB P&P Section I.2 Intercom Systems "*Intercoms are generally located in areas accessible by incarcerated persons (e.g., dayrooms, cells, classrooms, etc.). Each facility shall maintain an intercom system for the purpose of providing a means of communication between sworn staff and incarcerated persons. Intercom systems should be primarily used as a means of relaying and or summoning emergency assistance. Intercoms shall not be routinely muted or silenced.*" At 7:24pm, during a Supervisor Check, IP Lines was discovered in medical distress. Confidential statements were taken into consideration for the recommended finding. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

3. Misconduct/Medical – A Registered Nurse (RN) documented inaccurate medical records.

   Board Finding: Pending
   Staff Recommended Finding: Summary Dismissal
   Rationale: Per BWC footage and CCTV footage, on 05-12-26 at approximately 10:39am, a deputy assisted an RN with medication administration and contacted IP Lines in her cell. Per BWC footage, at no point during the interaction was IP Lines heard refusing any medication nor was she heard being counseled regarding medication refusal before staff exited her cell at 10:46am. At 10:53am, the RN submitted documentation for the medications he provided IP Lines. At 11:27am, the RN completed a Medical Refusal Form and documented Lines refused medication. The deputy's Arjis number was listed as a witness to the refusal. The deputy's BWC was activated during the entirety of the medication administration until 11:55am, at no point was IP Lines heard refusing medication nor was the RN heard counseling her on medication refusal. There was also no BWC footage of the deputy signing a medication refusal form. Confidential statements were considered. CLERB did not receive a signed complaint for this incident and the review board lacks jurisdiction over medical personnel who are non-sworn personnel. Per CLERB R&R 4.1 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 Office or the Probation department…"* The Review Board lacks jurisdiction.

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.

25-076/WILSON (Priority)

1. Excessive Force – Deputy 1 pushed Incarcerated Person (IP) Wilson on 03-14-25.

   Board Finding: Pending
   Staff Recommended Finding: Not Sustained
   Rationale: Complainant John Wilson alleged Deputy 1 used excessive force by pushing him while escorting him from Quad 203, causing him to slip and fall down a flight of stairs while handcuffed. On 03-14-25, at approximately 2:10am, Deputy 1 conducted a safety check. A verbal exchange occurred between IP Wilson and Deputy 1 regarding the volume of Deputy 1 two-way radio. Body Worn Camera (BWC) footage showed that IP Wilson was ordered out of his bunk and instructed to place his hands behind his back for handcuffing. Deputy 1 documented, *"I placed my right hand on IP Wilson's left forearm to guide him outside of Quad 203. IP Wilson immediately became non-compliant and actively resisted by tensing his arms, planted his feet on*

the floor, turned his front body towards my direction, and threw his left elbow backwards towards my front torso stating, 'Don't pull me around, don't pull me around'." Deputy 2 responded to assist with the escort and documented that he took control of Wilson's right arm. Both deputies documented that while escorting Wilson down the stairs, Wilson planted his feet and dropped his weight, causing deputies to lose their grip. Due to the limited camera angle, the footage did not fully capture all body positioning or movements immediately preceding the fall. Deputies 1 and 2 assisted Wilson to a standing position and escorted him to a medical holding cell. While the available evidence established that Deputy 1 used physical control techniques during the escort, it did not establish the cause of the IP Wilsons' fall because the CCTV footage did not capture the parties' positioning and the BWC footage provided only a limited perspective of the moments preceding the fall. SDSO P&P Section 2.49, Use of Force, stated, "*Employees shall not use more force in any situation than is reasonably necessary under the circumstances. Employees shall use force in accordance with law and established Office procedures, and report all use of force in writing.*" The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

2. Misconduct/Procedure – Deputy 1 failed to utilize de-escalation techniques on 03-14-25.

   Board Finding: Pending
   Staff Recommended Finding: Sustained
   Rationale: IP Wilson alleged Deputy 1 failed to appropriately de-escalate their interaction during a safety check on 03-14-25. Body Worn Camera (BWC) footage captured IP Wilson commenting on the volume of what he believed to be Deputy 1's radio. IP Wilson stated, *"Turn that shit down, people are trying to sleep."* Deputy 1 responded, *"What's wrong with you*?" and later stated, "*It's not a radio, it's a Body Worn Camera. You wanna keep talkin'*?" BWC footage showed Wilson roll over in his bunk and turn away from Deputy 1. Deputy 1 remained standing at Wilson's bunk for approximately five seconds before stating, *"That's what I thought."* As Deputy 1 began walking away, Wilson responded, *"Nah, you didn't think nothing man."* Deputy 1 replied, *"What's up then? Get up."* Wilson repeatedly asked, "Get up for what?" Deputy 1 radioed for an additional deputy and eventually responded, *"For disrespect, get up."* Wilson then complied with Deputy 1 orders to stand, face the wall, and place his hands behind his back, at which point he was placed in handcuffs and escorted to a holding cell outside the module. While in the holding cell, BWC footage captured Deputy 1 interrupting and speaking over IP Wilson on multiple occasions. Deputy 1 spoke over IP Wilson while reading him the Miranda admonishment. Body Worn Camera footage further captured Deputy 1 continuing to engage Wilson in verbal exchanges during escort to medical and throughout Wilson's medical evaluation. During the medical assessment, Deputy 1 interrupted Wilson while Wilson was speaking with medical staff and providing his account of the incident. Following a continued verbal exchange, Wilson asked Deputy 1, *"Why are you so argumentative?"* Deputy 1 continued engaging Wilson in verbal exchanges after Wilson initially turned away in his bunk and after IP Wilson had been detained and placed in the holding cell. Per P&P Section 11.7 De-Escalation, states, *"De-escalation is defined as the process of using strategies and techniques intended to decrease the intensity of a situation. De-escalation includes actions taken in an attempt to stabilize an incident to try and reduce the immediacy of a threat. Deputies should consider tactics and techniques that may persuade the suspect to voluntarily comply or may mitigate the need to use a higher level of force to resolve the situation safely. Deputies shall use de-escalation techniques, crisis intervention tactics, and/or alternatives to force when it is safe and feasible to do so. De-escalation does not require a deputy risk their safety or the safety of the public. The specific strategies and techniques utilized in de-escalation are further covered in training. The core concepts of de-escalation are as follows: Self-control – understanding of physical and psychological reactions of the public and law enforcement officers may assist in maintaining self-control; Effective communication – clear commands and questions, good observation and listening skills, and appropriate terminology will enhance the likelihood of success; Scene assessment and management – when possible, provides officers with an accurate picture of what is occurring and assists in the management of force options; Force options – reasonable use of force techniques may reduce situational intensity for the safety of all parties…"* The investigation disclosed sufficient evidence to prove the allegation by a Preponderance of the Evidence.

3. Misconduct/Procedure – Deputies 1 and 2 failed to provide IP Wilson access to medical care on 03-14-25.

   Board Finding: Pending

Staff Recommended Finding: Not Sustained
Rationale: Complainant John Wilson reported deputies failed to provide *"timely"* access to medical care after he fell while being escorted on 03-14-25. See Rationale 1. IP Wilson stated Deputy 2 returned to his holding cell after the other deputies had exited and asked whether he needed medical attention. There was no BWC footage or other independent evidence available to corroborate this interaction. Body Worn Camera footage captured Deputy 1 re-entering the holding cell at approximately 4:10am. Wilson stated, *"Yea, I'm not feeling too good*." Deputy 1 responded, *"We're gonna take you to the nurse right now."* IP Wilson later requested a wheelchair. Deputies exited the holding cell and returned at approximately 4:23am with a wheelchair. Wilson was subsequently escorted to medical staff and arrived for evaluation at approximately 4:30am. SDSO P&P Section 11.24, Aftercare, states, *"Whenever a subject requires or reasonably requests medical attention after a use of force incident, a deputy shall promptly provide medical attention, request medical aid, and/or transport them to an emergency medical facility when safe to do so."* The available evidence did not clearly establish whether IP Wilson requested medical attention during the period immediately following the incident or if it was offered by Deputy 2. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

4. Misconduct/Procedure – Deputy 2 failed to activate his Body Worn Camera (BWC) per policy on 03-14-25.

Board Finding: Pending
Staff Recommend Finding: Sustained
Rationale: Upon review of the evidence, it was discovered Deputy 2 failed to activate his BWC during this incident. On 03-14-25, Deputy 2 responded to assist Deputy 1 after being requested by radio. Deputy 1's BWC captured Deputy 2 physically assisting with the escort of handcuffed IP Wilson; however, Deputy 2 did not activate his own BWC during the initial contact or during the reportable use-of-force incident when IP Wilson fell on the stairwell. Although Deputy 2 later activated his BWC, the activation occurred after the incident had already taken place. Per SDSO P&P Section 6.131 Body Worn Camera, *"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 sufficient evidence to prove the allegation by a Preponderance of the Evidence.

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.

25-106/MOODY (Death)

1. Death Investigation/Barricade – Christopher Jay Moody died while barricaded in his home on 09-03-25.

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 09-03-25, Deputies 1 and 2 received a call to check the welfare of Christopher Moody at his residence in Ramona. Prior to their arrival, deputies were told Moody had a history of drug abuse, was possibly in possession of firearms, and had not responded to any phone calls since the previous day. Per Body Worn Camera (BWC) footage, deputies knocked on the front door but did not receive an answer. Deputies walked around the house looking into windows. Per BWC, deputies discovered a broken bedroom window on the side of the house, observed two dogs inside and blood near the window. While they were looking into the bedroom, Deputy 2 advised he could see Moody and called out to him. Moody did not answer and instead moved a closet door into a hallway which the deputies believed was an attempt to "*barricade*" himself. While Moody was out of sight, both deputies heard a sound consistent with someone loading a firearm. Deputies called out to Moody several times to make verbal contact but did not receive an answer. Deputies called for additional units and a supervisor, then withdrew toward their vehicles. SDSO Section 11.7 De-escalation said, "*De-escalation is defined as the process of using strategies and techniques intended to decrease the intensity of a situation. De-escalation includes actions taken in an attempt to stabilize an incident to try and reduce the immediacy of a threat. Deputies should consider tactics and techniques that may persuade the suspect to voluntarily comply or may mitigate*

the need to use a higher level of force to resolve the situation safely. Deputies shall use de-escalation techniques, crisis intervention tactics, and/or alternatives to force when it is safe and feasible to do so. De-escalation does not require a deputy risk their safety or the safety of the public." Upon the supervisor's arrival, it was decided deputies would withdraw to a safer distance and determine their course of action. The supervisor spoke with Moody's spouse and obtained relevant background regarding Moody including a deteriorated mental state, recent drug use, and photographic evidence indicating he was in possession of firearms. A records check revealed Moody was a convicted felon and prohibited from possessing firearms. A nearby elementary school was evacuated, and a search warrant was obtained. SDSO's Special Enforcement Detail was unavailable so the search warrant was served by the Escondido SWAT team at about 3:23pm, approximately six hours after the initial radio call. Per SDSO Section 9.4 Tactical Assistance, "*The Special Enforcement Detail (SED) is always used in support of the Incident Commander and they receive their missions from the Incident Commander. The goal of SED is risk reduction in the protection of life and property. Requests for activation of SED shall be initiated by a supervisor and can be based upon the following criteria: Barricaded Suspect: Was involved or is believed to have been involved in a serious criminal act. Is believed or known to be armed. Is believed to be a threat to the lives and safety of citizens and/or law enforcement personnel. Is in a position of advantage, affording cover & concealment. Refuses to submit to arrest.*" During the service of the search warrant, SWAT located Moody inside a bedroom closet, and a SWAT medic pronounced Moody deceased. An autopsy was performed by the Medical Examiner's office who determined Moody, "*died as a result of the combined toxic effects of methamphetamine and buprenorphine*" and the manner of death was an "*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.

25-114/BANZHOFF (Routine)

1. Excessive Force – Deputies 1, 3 and 4 used force against Angela Banzhoff on 09-24-24.

   Board Finding: Pending
   Staff Recommended Finding: Summary Dismissal
   Rationale: The complainant, Angela Banzhoff, alleged a SDSO deputy used excessive force when arresting Banzhoff. Banzhoff stated, "*The Sherrif's* [sic] *asked me 3X what had happened & on the 3rd "nothing happened" I was ripped from behind & placed I* [sic] *cuffs. It was so hard that it bruised/broke my ribs. They then pulled my arms over my head and as I was screaming for them to stop they walked me out to the cop car…"* A review of the evidence identified Deputy 1 as the only deputy matching the description provided by Banzhoff. Banzhoff told deputies she sustained scratches on her right side when she fell on a lamp. Banzhoff refused multiple offers to have medics evaluate her. Body Worn Camera (BWC) verified Deputy 1 was present when Deputy 3 arrested Banzhoff but Deputy 1 did not *participate* in the arrest or handcuffing. Deputy 3 did not use force when handcuffing Banzhoff with her hands behind her back. Deputy 4 assisted Deputy 3 by removing objects from Banzhoff's hand and guiding one arm behind her back. Deputy 4 did not use force. Banzhoff told deputies immediately after handcuffing that she had a *"broken rib"* from falling on a lamp *prior* to deputies' arrival. Deputies 1 and 3 asked Banzhoff repeatedly to walk to the patrol car, but Banzhoff would not walk. Deputies warned Banzhoff force would be used if she did not voluntarily walk. Deputies 1 and 3 escorted Banzhoff to their vehicle by holding onto her arms and using pressure to move her forward. Banzhoff remained non-compliant and planted her feet, bent over and dropped her weight until she reached the sidewalk. Deputies placed Banzhoff in the back of a patrol car. Banzhoff waived her Miranda rights and provided a statement that included details about her boyfriend causing an injury to her right rib, *"… picked me up and threw me against the lamp… The lamp broke in my rib cage. I fell to the ground…I called you guys…told me when you guys were outside. I was in the bathroom trying to put ice on it…I couldn't get up because I thought it was broken."* Deputy 2 asked Banzhoff, *"Right or left rib?"* Banzhoff replied, *"right."* Per SDSO P&P 11.9 Types 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."* Per SDSO P&P 11.10 Types of Control, *"Verbal Control: refers to advisements, warnings, verbal persuasion, or commands given by a deputy. Physical Control: is the application of specific control holds, takedowns, personal body weapons, or other techniques applied by a deputy as a means of overcoming resistive, assaultive, or life-threatening behavior."*

Per SDSO P&P 11.12 Physical Control Techniques, "*Pain compliance techniques or pressure point control tactics may be effective in controlling passively noncompliant or actively resistant subjects…*" Deputy 3 took Banzhoff to the hospital for treatment before booking Banzhoff into Las Colinas Detention Facility. Pursuant to CLERB Rules and Regulations, 4.1.2 Complaints: Jurisdiction, CLERB investigators determined CLERB does not have jurisdiction because the complaint was not timely filed. The Review Board lacks jurisdiction.

2. Misconduct/Procedure – Deputies 2, 3 and 4 failed to comply with SDSO's Body Worn Camera policy on 09-24-24.

   Board Finding: Pending
   Staff Recommended Finding: Sustained
   Rationale: See Rationale 1. CLERB received evidence pertaining to this case on 10-02-25. After reviewing the BWC evidence it was discovered that Deputies 2 and 3 muted their BWC's during the investigation without documenting the reason for muting in writing. Deputy 4 turned off his BWC and did not reactivate his BWC when he returned to the residence to assist Deputy 2 with the investigation which included interaction with the victim. Per SDSO P&P 6.131 Body Worn Cameras, "*Muting is generally discouraged…In all cases where BWC video is muted, it shall be documented in writing*..." Additionally, per SDSO P&P Body Worn Cameras, *"...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*." Deputies 2, 3 and 4 provided confidential statements that were considered in arriving at the recommended finding. The investigation disclosed sufficient evidence to prove the allegation by a Preponderance of the Evidence.

25-132/PARRA (GBI)

1. Use of Force Resulting in Great Bodily Injury – Deputies Robert Forbes, Jaime Gomez Jr. and Paul Sterbenz II, used force against Miguel Parra on 10-30-25.

   Board Finding: Pending
   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 10-30-25, detectives from the Border Crime Suppression Team (BCST) conducted a traffic stop on Miguel Parra for vehicle code violations. Parra yielded in a busy retail parking lot. Detective Gomez arrived on scene and told Parra to exit his vehicle so they could conduct an exterior narcotics "sniff" of Parra's vehicle, but he declined. Parra then started his engine and tried to roll up his driver's side window. A struggle ensued with two detectives trying to keep Parra from fleeing. Parra was able to break free from the detectives and fled through the retail parking lot at a high rate of speed. A pursuit ensued where Parra ran stop signs and reached speeds of 55 mph on residential streets. Parra parked his vehicle and fled on foot, jumping two residential fences and entering an open slider of a residence. Parra fled through an uninvolved residence. Detectives caught up to Parra and a struggle ensued. Throughout the incident, Parra was told multiple times in Spanish and English to stop resisting. It took multiple detectives to gain control of Parra. Detectives used fist strikes on Parra's face as he actively kicked and tried to escape. A drive stun was also used on Parra's lower leg. Parra continued to struggle with the detectives, until placed in handcuffs. During a search of Parra's vehicle, 18.6 pounds of methamphetamine was located. Parra sustained a broken nose and abrasions, and two detectives sustained minor injuries. All were treated at a medical facility, and Parra was subsequently booked into jail. Per P&P Section 11.4 Use of Force Legal Standards, "*In determining whether a deputy's use of force is reasonable in a particular case, it is necessary to evaluate the facts and circumstances confronting the deputy at the time force was used… All the surrounding circumstances will be considered, including whether the subject posed an imminent threat to the safety of the deputy or others…"* Per P&P Section 11.11, Use of Force Matrix and P&P Section 11.13, Personal Body Weapons "*can be used to strike available targets to control an actively resistant or assaultive subject."* Per P&P Section 11.2 Use of Force Definitions, "*A deputy 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. Deputies should consider the totality of the circumstances, including the nature and immediacy of any threats posed to deputies and others."* Per P&P Section 11.18, Conducted

Energy Devices (Tasers): *"Conducted Energy Devices (CEDs) are less lethal devices that utilize electrical impulses for pain compliance and/or to temporarily incapacitate a subject. CEDs are an intermediate force option that may only be used to control subjects displaying assaultive behavior. Deputies shall only use the shortest duration of CED exposure that is objectively reasonable based on the circumstances. Deputies should constantly reassess the subject's behavior, reaction, and resistance before initiating or continuing the exposure. Multiple applications or continuous cycling of a CED resulting in an exposure longer than 15 seconds (whether continuous or cumulative) may increase the risk of serious bodily injury or death and should be avoided if possible. If the CED is ineffective, deputies should consider alternate control measures*." The investigation showed the alleged act did occur but was lawful, justified, and proper.

25-133/GUTIERREZ (GBI)

1. Use of Force Resulting in Great Bodily Injury – Deputy Erick Resendiz deployed his canine partner resulting in injury to Francisco Gutierrez on 10-30-25.

   Board Finding: Pending
   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 10-30-25 at 9:04pm, deputies were alerted by Pauma Tribal Police of a subject, Francisco Gutierrez, who had just left their casino, and had an outstanding felony warrant. Deputies Resendiz and Padilla arrived and located Gutierrez walking westbound in the eastbound lanes of traffic on State Route 76. "*The road that Gutierrez was traveling on was very desolate, dimly lit, and heavily wooded on either side."* Both deputies issued commands for Gutierrez to stop walking, told Gutierrez he had a felony warrant, and told him he would be bit if he continued to flee from deputies. Gutierrez ignored the commands and canine Chivas was deployed to apprehend Gutierrez. *"Using 'Chivas' to effect the arrest of Gutierrez allowed us to apprehend Gutierrez with less risk or injury to Deputies and Gutierrez as he was walking on a highway…. he could have fled into the dark wooded area where he would have posed a greater danger to deputies and greater force could have been needed to apprehend him."* Canine Chivas made contact with Gutierrez's right leg below his knee. Gutierrez was treated by medics and transported to a hospital. Gutierrez was arrested for the outstanding felony warrant. Per Section 4.4 San Diego Sheriffs K-9 Unit Manual: "*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…In situations where any force used can cause serious injury or death, there is a requirement that, whenever feasible, the deputy must first warn the suspect that force will be used if there is not compliance. The handler should allow a reasonable time for a suspect to surrender.* Per Section 11.21 Canines: *Law enforcement trained canines are a viable intermediate force option when employed under the direction of their handlers in accordance with the Sheriff's Canine Unit Manual. Canines may be deployed to locate, apprehend, or control suspects when the handler has evaluated the severity of the crime, level of resistance, and whether the suspect's actions pose an immediate threat to the safety of deputies or others.* Per Section 11.24 Aftercare: *Whenever a subject requires or reasonably requests medical attention after a use of force incident, a deputy shall promptly provide medical attention, request medical aid, and/or transport them to an emergency medical facility when safe to do so."* The investigation showed the alleged act did occur but was lawful, justified, and proper.

25-146/DARIAN (Routine)

1. Misconduct/Procedure – Deputies 1 and 2 failed to conduct their investigation in accordance with SDSO Policy and Procedure on 12-10-24.

   Board Finding: Pending
   Staff Recommended Finding: Unfounded

Rationale: Complainant Kayvon Darian alleged Deputies 1 and 2 failed to conduct a "*proper"* investigation into the battery incident that occurred on 12-10-24. Darian further alleged that Deputies 1 and 2 were *"biased"* due to Deputy 1 being the arresting officer in a previous domestic violence case involving Darian. On 12-10-24, deputies were dispatched to a report of a physical altercation between neighbors regarding a parking dispute. Upon arrival, Deputy 2 contacted Darian while the alleged suspect, Ehrich Steinmetz, was detained at the scene by responding deputies. Deputy 2 documented that Darian was bleeding from the top of his head and that Darian reported that Steinmetz punched him in the face, causing him to fall to the ground. Darian further reported that Steinmetz continued striking him while he was on the ground. Deputy 2 also documented injuries observed on both Darian and Steinmetz. Deputy 2 obtained statements from Darian, Steinmetz, and two witnesses. The witnesses corroborated with Darian's account that Steinmetz approached Darian and punched him. Steinmetz admitted telling one of the witnesses to move his vehicle and acknowledged punching Darian, claiming he believed he was defending himself. Santee Fire Department personnel responded to the scene and evaluated both Darian and Steinmetz. Deputy 2 documented Darian's injuries as a small laceration to the top of his head and an abrasion to his left knee. Both parties declined additional medical treatment and signed medical release forms. BWC captured Deputy 2 explaining the Citizen's Arrest procedure to Darina who stated he was not desirous of prosecution. Shortly thereafter, Darian requested prosecution and an additional follow-up investigation was conducted by Deputy Yniguez. Deputies 1 and 2 conducted an on-scene investigation that included identifying and interviewing involved parties and witnesses, documenting injuries, obtaining medical evaluations, attempting to locate video evidence, explaining the citizen's arrest process, and documenting Darian's stated position regarding prosecution at the time of the initial investigation. Deputies 1 and 2 provided confidential statements that were taken into consideration for the recommended finding. Per SDSO P&P Section 6.71 Crime Case Reports: "*Crime Reports and Incident Reports require a Crime/Incident Report Form so that all pertinent information not included in arrest reports may be captured. Courtesy Reports should be written for other agencies and Sheriff's stations when it would be impractical for the victim to return to the jurisdiction or location where the incident occurred. A Crime/Incident Report shall be completed for the following Uniform Crime Reporting (UCR) Part I and Part II crimes and listed incidents: Part I Crimes: Homicide, Rape, Robbery, Assault (Felony and Misdemeanor), Burglary, Larceny/Theft (Felony and Misdemeanor), Auto Theft, and Arson. Part II Crimes: All other reported felony crimes; all other reported misdemeanor crimes; incidents (non-crimes); domestic violence incidents; lost/found property; death investigations (including industrial accidents if death occurs); suicides; attempted suicides; deputy-caused property damage (damage done by a deputy during the course of his/her duties, i.e., forced entry for medical emergencies, check-the-welfare calls, search warrant service, etc.); and arrests. When the only crime victim is the State of California, e.g., narcotics arrests, and an arrest has been made, a Crime/Incident Report Form will not be required for felony and misdemeanor arrests. Only the Arrest Report or Juvenile Contact Report is needed. Courtesy Reports: When a deputy writes a Courtesy Report for another agency or Sheriff's station, he/she will tell the reporting party that the report will be forwarded to the agency or Sheriff's station of jurisdiction. The deputy will attempt to notify the correct agency by telephone and fax or email the report to the appropriate jurisdiction, if possible. The original report will be forwarded through the U.S. Mail to the agency of jurisdiction. Messenger mail may be utilized to route reports between Sheriff's stations. Deputy's Reports: An Officer's Report may be completed to report a miscellaneous incident or provide supplemental information when appropriate.*" SDSO P&P Section 2.55, Non-Biased Policing, states, *"Members of the San Diego County Sheriff's Office are prohibited from inappropriately or unlawfully considering race, ethnicity, religion, national origin, sexual orientation, gender, or lifestyle in deciding whether enforcement intervention will occur."* The investigation clearly established that the allegation is not true.

2. Misconduct/Procedure – Deputy 3 failed to submit an investigation to the District Attorney's Office in a "*timely"* manner.

   Board Finding: Pending
   Staff Recommended Finding: Sustained
   Rationale: Complainant Kayvon Darian alleged Deputy 3 failed to submit his investigation to the District Attorney's (DA) Office in a *"timely"* manner. On 12-12-24, Darian contacted Deputy 3 and advised that he wished to pursue criminal charges related to the battery incident that occurred on 12-10-24. Deputy 3 reopened the investigation, which included obtaining an additional statement from Darian, requesting medical

records, reviewing photographs, attempting to locate video evidence, and evaluating the case for submission to the DA's Office. On 07-26-25, Darian provided Deputy 3 with copies of his medical records after Deputy 3 advised that he had been unable to obtain them from the hospital. The medical records documented a laceration to the top of Darian's head that required five sutures. On 08-29-25, Deputy 3 emailed Darian advising that the case was going to be submitted to the DA's Office *"by the end of next week."* Deputy 3 continued, *"Once the follow-up report and attachments are fully received by their office, I will send you an update."* Darian attempted to reach Deputy 3 on multiple occasions following the email to obtain a case status update and later reported that he learned the case had not yet been submitted. On 12-08-25, the case was submitted to the DA's Office, approximately two days before the statute of limitations for misdemeanor battery expired. The investigation did not identify any outstanding investigative leads, pending evidence requests, or supervisory direction that prevented submission of the case after receipt of the medical records on 07-26-25. The evidence showed the case remained unsubmitted until 12-08-25, despite Deputy 3 advising Darian on 08-29-25 that the matter would be submitted to the District Attorney's Office by the end of the following week. When the case was ultimately submitted, the DA's Office reviewed the matter and declined to file criminal charges. SDSO P&P Section 2.30, Failure to Meet Standards states, *"Employees shall properly perform their duties and assume the responsibilities of their positions. Employees shall perform their duties in a manner which will tend to establish and maintain the highest standards of efficiency in carrying out the mission, functions, and objectives of this Office. Failure to meet standards may be demonstrated by a lack of knowledge of the application of laws required to be enforced; an unwillingness or inability to perform assigned tasks; the failure to conform to work standards established for the employee's position; the failure to take appropriate action on the occasion of a crime, disorder, or other condition deserving police attention; absence without leave; unauthorized absence from the assignment during a tour of duty; the failure to submit complete and accurate reports on a timely basis when required or when directed by a supervisor"* The investigation disclosed evidence sufficient to prove the allegation by a Preponderance of the Evidence.

25-152/DEL MORAL (Routine)

1. Misconduct/Procedure – Deputy 1 "*refused"* to classify Renata Del Moral as a crime victim.

   Board Finding: Pending
   Staff Recommended Finding: Action Justified
   Rationale: Complainant Del Moral alleged on 03-14-25, deputies responded to a report of domestic violence/vandalism to her tenant's vehicle and property. The suspect was believed to be her tenant's ex-boyfriend. The suspect rammed his vehicle into her tenant's vehicle which was parked in the driveway to her property. The force of the collision caused her tenant's vehicle to collide into the wall of tenant's residence causing structural damage. Del Moral resided in the adjoining duplex and the property ultimately belonged to her. The tenant was the intended victim of vandalism and was listed as the primary victim in the crime report with Del Moral being listed as an "*Other Entity"* with cost estimates for the structural damage included in the narrative. Deputy 1 was the assigned investigator for the case. On 05-22-25, Deputy 1's Investigative Report noted the District Attorney's Office decision not to prosecute and cited their reasoning. Del Moral stated she spoke with Deputy 1 over the phone and alleged that Deputy 1 "*refused"* to classify her as a crime victim in the police report. Audio recordings of the telephone conversations showed Deputy 1 explained to Del Moral the original report had already been submitted to the District Attorney's Office, and he was not permitted to change any facts and/or details in the original report. On 08-29-25, Deputy 1 completed a report under a new case number and documented the details of the incident that pertained solely to Del Moral's involvement and the damage to her property. Deputy 1 advised Del Moral that compensation for her property damage was a civil matter that would need to be addressed in civil court or through her insurance provider. The alleged act did occur but was lawful, justified, and proper.

2. Serious Misconduct/False Reporting – Deputy 1 wrote "*false statements*" in his report.

   Board Finding: Pending
   Staff Recommended Finding: Unfounded
   Rationale: Complainant Del Moral alleged that Deputy 1 wrote a false sentence in his written report that she believed was "*intentional misrepresentation"*. The sentence in question was not attributed to Del Moral's

official statement; it was a statement of fact placed under the "*Follow-Up Investigation"* header, not under the *"Statement of Del Moral"* header. 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."* Confidential statements were considered. The investigation clearly established that the allegation is not true.

3. Misconduct/Procedure – Deputy 1 failed to provide Del Moral with a copy of the police report.

   Board Finding: Pending
   Staff Recommended Finding: Action Justified
   Rationale: Complainant Del Moral stated she contacted Deputy 1 on numerous occasions requesting a copy of the police report and the identity of the suspect. Del Moral said Deputy 1 failed to provide her with either. An audio recording of the phone call confirmed that Deputy 1 informed Del Moral due to the nature of the incident, he would not be permitted to release certain information to her without a subpoena. On 08-29-25, he completed a new report documenting the details that were available to be released to her without a subpoena. All record requests to include reports and suspect information are handled by the Records and ID Division and not individual deputies. Per SDSO P&P Section 6.123, Subpoena Acceptance and Compliance Procedures Subsection 2: "*Personal Appearance and Records must be accepted by personal service only. Subpoenas for Records Only (Other than "Custodian of Records") may be accepted by fax from the District Attorney, the Public Defender, the Alternate Public Defender, and the Multiple Conflicts Office, provided the criteria in Section 8 are met. What to do with the Subpoena? The same procedures apply as for Appearance-Only Subpoenas, except as follows: The witness must attend court with the records described in the subpoena, unless the records are not in the custody or control of the witness. Completed reports are not in the custody or control of individual deputies. A deputy or any employee receiving a subpoena that requires them to bring San Diego County Sheriff's Office to court a copy of the completed report should telephone the attorney issuing the subpoena, and inform the attorney that they will not produce a copy of the completed report. The attorney should be advised that he/she may be able to subpoena a report by issuing a Records Only subpoena to the Custodian of Records of the Sheriff's Records Division, and serving the subpoena on the Sheriff's Records Division… For Medical Records only, the subpoena should be served to Chief, Medical Records..."* The alleged act did occur but was lawful, justified and proper.

4. Misconduct/Procedure – Deputy 1 *"*omitted*"* evidence in response to Del Moral's subpoena for records.

   Board Finding: Pending
   Staff Recommended Finding: Unfounded
   Rationale: Complainant Del Moral alleged that a subpoena for records was submitted to SDSO and Deputy 1 *"deliberately omitted"* vital documents and provided incomplete records in response to that subpoena. All subpoena and records requests are the responsibility of the San Diego County Sheriff Records and ID Division. All record requests to include reports, evidence, and suspect information are handled by the Records and ID Division and not individual deputies. Deputy 1 would not have the authority to determine what information was eligible to be released to Del Moral. See Rationale 3 for applicable SDSO policy. The investigation clearly established that the allegation is not true.

5. Misconduct/Procedure – Deputies 2, 3, 4, and 5 muted their Body Worn Camera's (BWC) on 03-14-25.

   Board Finding: Pending
   Staff Recommended Finding: Sustained
   Rationale: Through the course of investigation, it was discovered that deputies muted their BWC's while on scene and did not document the reason for muting in writing. Per 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." Confidential statements were considered for the recommended finding. The investigation disclosed sufficient evidence to prove the allegation by a Preponderance of the Evidence.

25-153/GLASGO (GBI)

1. Excessive Force – Deputies 1, 2, 4 & 5 "*assaulted*" the aggrieved on 12-12-25.

   Board Finding: Pending
   Staff Recommended Finding: Unfounded
   Rational: The complainant, Judith Glasgo, reported on or about 12-12-25, the aggrieved was *"assaulted by four deputies,"* sustained a head injury during the assault and was transported to the hospital. A review of documents, reports, BWC and CCTV showed on 12-12-25, the aggrieved was contacted by deputies for vandalizing and destroying property in his cell. The aggrieved defecated and threw a large pile of debris outside his cell door. Deputies escorted the aggrieved to the recreation yard so they could facilitate a cleanup of the cell area. Initially, two deputies were conducting the escort, but the aggrieved stopped halfway there and sat down. Two more deputies came into the module, and the four deputies attempted to convince the aggrieved to move. After about twenty minutes, the aggrieved was escorted by deputies into the yard. No force was used and the aggrieved did not sustain any injuries during this contact. Once the cell area was cleaned, the aggrieved was moved back to his cell without incident. The following day, 12-13-25, during a safety check, deputies discovered the aggrieved had a head injury that was bleeding. The aggrieved reported hitting his head against the inside wall of his cell. The deputies removed the aggrieved from his cell without incident and escorted him to the nurse's station. The aggrieved was assessed by a medical provider and transported to a hospital where he was admitted for multiple days for his head injury and mental health issues. The investigation clearly established that the allegation is not true.

2. Misconduct/Procedure – Deputy 3 placed the aggrieved in Administrative Separation (AS) on 11-15-25.

   Board Finding: Pending
   Staff Recommended Finding: Action Justified
   Rationale: The complainant alleged due to *"extreme mental illness"* the aggrieved was not suitable for AS. A review of the Inmate History Summary Report showed the aggrieved was in AS from 11-15-25 to 01-09-26. The classification deputy noted the IP was placed in AS for *"continual failure to adjust and conform to minimum standards."* Per DSB P&P section J.3.1, Segregation: Definition and Use, *"Those who have displayed a continual failure to adjust and conform to the minimum standards expected of those in mainline housing or designated special housing. The incarcerated person's behavior is either criminal in nature or disruptive to the safe operation of the facility."* Per Section J.3, Administrative Separation, "*Administrative separation shall consist of separate and secure housing, but shall not involve any other deprivation of privileges, other than is necessary to obtain the objective of protecting the incarcerated person, staff, or public*." The classification deputy also classified the IP as Protective Custody, "*Protective custody (P/C) is the voluntary or involuntary placement of an incarcerated person into separate and secure housing when there is a verified threat against their life, whether stated or implied, or when an incarcerated person's circumstances render them a target for physical violence*." The investigation showed the alleged act did occur but was lawful, justified, and proper.

3. Misconduct/Procedure – Unidentified deputies failed to conduct *"required reviews"* for the aggrieved's continued placement in Administrative Separation (AS).

Board Finding: Pending
Staff Recommended Finding: Unfounded
Rationale: The complainant reported, *"the Jail Population Management Unit (JPMU) reviews his status every seven days and documents this in the JIMS system,"* while in AS. The complainant was concerned these reviews were not conducted for the aggrieved. Per the JIMS Inmate History Summary, AS reviews were completed at least every seven days with comments listed in the entry as required by various deputies. Per Section J.3.VII.A.1&2, Administrative Separation Monitoring, *1. "JPMU will ensure the status of each separated person listed in sections II and III.D is reviewed at least every seven days. The objective is to return separated persons to the general incarcerated population or designated special housing when appropriate. 2. The seven-day review will be documented in JIMS. Comments will be entered into each person's JIMS history to describe the need for continued placement. The removal of a person from administrative separation housing will be documented in JIMS on an incident report."* The investigation clearly established that the allegation is not true.

4. Misconduct/Medical – Unidentified medical staff failed to conduct reviews of the aggrieved while in Administrative Separation (AS).

Board Finding: Pending
Staff Recommended Finding: Summary Dismissal
Rationale: The complainant did not believe that Brandon should have remained in AS for any length of time due to his mental illness. CLERB was unable to obtain medical records due to lack of authorization from the aggrieved. Per Section J.3, Administrative Separation Health Staff, "*Health staff and mental health staff will receive a JIMS notification when an incarcerated person was placed into administrative separation housing based on a mental health recommendation due to a person's increased risk for self-harm. Mental health staff and medical staff will review the person's health record to determine whether existing medical, dental or mental health needs require accommodation. Examples of such conditions include but are not limited to: withdrawal, dementia, Alzheimer's, diagnosed mental illness, history of self-harm, prior Detentions Safety Program (DSP) placement or diagnosed obstructive sleep apnea. Health staff will document the review in the person's health record and notify the watch commander of any accommodation needed. Health staff will monitor all incarcerated persons housed in administrative separation housing. A qualified health care professional will conduct a mental health follow-up three days each week on all separated persons. A Qualified Mental Health Provider (QMHP) will monitor and assess all separated persons at least one day each week. Documentation of separation rounds will be made in the person's health record and will include significant health findings, signs of physical and/or psychological deterioration and other signs or symptoms of failing health. Health staff shall notify the watch commander if any of the above are discovered during a "wellness check" (refer to Medical Services Division Operations Manual S.4, section I.D)."* Medical Services Division, Section S.4, D.2.A.B, *"The frequency of health monitoring will be based on the degree of separation. Documentation of segregation rounds will be made on individual logs, or cell cards, or in the patient's health record, and includes the date and time of the contact, the signature or initials of the medical staff making the rounds. a. Patients under extreme separation with little or no contact with other individuals are monitored daily by medical staff and at least once a week by mental health staff. b. Patients who are segregated and have limited contact with staff or other patients are monitored 3 days a week by medical or mental health staff."* Per CLERB's Rules and Regulations, 4.1, CLERB lacks jurisdiction over medical personnel in this complaint

26-028/FOSTER (GBI)

1. Use of Force Resulting in Great Bodily Injury – Deputy Jason Bunch used force against Incarcerated Person Jeremiah Foster on 02-26-26.

Board Finding: Pending
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 02-26-26, Deputies arrested Foster for a Court Order Violation and Obstruction, and he was transported to San Diego Central Jail (SDCJ). Body Worn

Camera (BWC) and CCTV footage showed Foster called Deputy Bunch a "*bitch"* and threatened to assault him during his arrest and booking process. Deputies accommodated Foster's request to change seats, however, once Foster was standing, he refused to sit down. Deputies issued numerous verbal commands instructing Foster to sit, however, he refused to comply. Deputy Bunch grabbed Foster's left arm, and another deputy grabbed Fosters right arm and they guided Foster back towards a chair located between a metal table and a wall. Deputies gave Foster repeated verbal commands to sit, however, he tightened his body, puffed out his chest and kept his legs straight which prevented deputies from forcing him into a seated position. Deputy Bunch attempted to grab Foster's leg and Foster kicked at Deputy Bunch. Foster repeatedly told Deputy Bunch "*your breath stinks"* before spitting in Deputy Bunch's face. Deputy Bunch documented that the saliva entered his eyes, nose, and mouth and stated, "*In defense, I shut my eyes and mouth to prevent anymore saliva from entering. At the same time, without the ability to see, I quickly punched Foster in the face with my right hand 4 times to stop the threat of another attack."* Deputies forced Foster onto the floor where a spit restraint device was applied over Foster's head. San Diego Fire Department and Paramedics responded, and Foster was transported to a hospital by ambulance for clearance prior to booking. During the transport, paramedics administered a sedative to Foster following his attempts to remove his restraints, remove the spit restraint device, and repeated attempts to kick medical equipment. Foster was medically cleared by hospital staff and transported back to SDCJ. Upon arrival, a blood draw search warrant was executed due to Deputy Bunch's exposure to Foster's bodily fluids. Foster refused to comply with the warrant and was placed on a gurney. Foster continued to thrash his body, requiring several deputies to hold him still so the phlebotomist could complete the procedure. Foster was booked for the original charges along with additional charges of gassing a police officer and obstructing a police officer using threats, violence, or force. Per SDSO P&P Section 2.49, Use of Force: "*Employees shall not use more force in any situation than is reasonably necessary under the circumstances. Employees shall use force in accordance with law and established Office procedures, and report all use of force in writing."* Per SDSO P&P Section 11.9, Types of Resistance: *"Passive Noncompliance: is represented by not responding to verbal commands but also offers no physical form of resistance. Active Resistance: refers to physically evasive movements to defeat a deputy's attempt at control, including bracing, tensing, running away, or verbally or physically signaling an intention to avoid or prevent being taken into or retained in custody. Assaultive Behavior: is represented by aggressive or combative behavior, attempting to assault the deputy or another person, or verbally or physically displaying an intention to assault the deputy or another person. Life-Threatening Behavior: refers to any action likely to result in serious bodily injury to or death of the deputy or another person (other than the subject)."* The investigation showed that the alleged act did occur but was lawful, justified, and proper.

Consent Agenda for Cases Recommended for Summary Dismissal pursuant to CLERB Rules and Regulations, Section 15: Summary Dismissal: (6)

After reviewing the Investigative Report and records, CLERB may summarily dismiss a case ("Summary Dismissal") upon recommendation of the Executive Officer, its own motion, or that of the Subject of Investigation. Parties to the complaint shall be notified of a proposed Summary Dismissal and may appear to argue for or against Summary Dismissal. Any party to the complaint or member of the public wishing to speak for or against Summary Dismissal in any of the cases listed in the Consent Agenda below may provide public comment under Section 3. of this Agenda.

All cases listed under this section are considered appropriate for Summary Dismissal pursuant to CLERB Rules and Regulations Section 15 (a)-(f), and will be acted upon in one motion, either by the Board on its own motion, or that of the Executive Officer. There will be no separate deliberation of these items unless a member of the Board so requests, in which event, the item will be considered separately at the end of the Closed Session agenda.

25-099/DINCKAN (Summary Dismissal)

1. Misconduct/Procedure – The San Diego Superior Court "*disregarded*" evidence.

   Board Finding: Pending
   Staff Recommended Finding: Summary Dismissal

Rationale: On 08-22-25, Ken Dinckan submitted a complaint to CLERB with allegations related to San Diego Superior Court proceedings. 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. The Review Board lacks jurisdiction.

25-105/WANG (Summary Dismissal)

1. Misconduct/Procedure – Unidentified San Diego Police Officer(s) lost Incarcerated Person Wang's property on 06-21-25

   Board Finding: Pending
   Staff Recommended Finding: Summary Dismissal
   Rationale: The complainant, Christy Wang, alleged unidentified San Diego Police Officers (SDPD) were negligent and lost her ring during her arrest. The complainant noted the ring was listed on the personal property form but upon release from custody, the ring was not in her property. The complainant last recalled seeing the ring attached to a pen that was clipped to the arresting officer's uniform. The complainant was provided with information to file a complaint with the appropriate entity. Pursuant to CLERB Rules and Regulations, Section 4.1.2, Jurisdiction, CLERB does not have jurisdiction over members of the SDPD. The Review Board lacks jurisdiction.

25-107/BERNABE (Summary Dismissal)

1. Criminal Conduct – A prior Honorary Deputy Sheriffs Association member impersonated a Sheriff's Deputy and drove "*under the influence.*"

   Board Finding: Pending
   Staff Recommended Finding: Summary Dismissal
   Rationale: Complainant Martha Bernabe alleged misconduct of an "*off-duty*" "*deputy*" who drove "*under the influence*." CLERB was informed the subject was a prior Honorary Deputy Sheriffs Association Member. The Honorary Deputy Sheriff's Association is an organization of *business, community leaders and service-minded citizens dedicated to supporting law enforcement countywide.* They are non-sworn personnel. This complaint was forwarded to the Sheriff's Department for criminal investigation. 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.

2. Criminal Conduct – A prior Honorary Deputy Sheriffs Association member impersonated a Sheriff's Deputy and drove "*without insurance.*"

   Board Finding: Pending
   Staff Recommended Finding: Summary Dismissal
   Rationale: Complainant Bernabe alleged misconduct of an "*off-duty*" "*deputy*" who drove "*without insurance*." See #1. 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.

3. Misconduct/Procedure – A prior Honorary Deputy Sheriffs Association member impersonated a Sheriff's Deputy and "*abuse*[d]" their authority and "*misuse*[d]" their "*law enforcement status*."

   Board Finding: Pending
   Staff Recommended Finding: Summary Dismissal
   Rationale: Complainant Bernabe alleged misconduct of an "*off-duty*" "*deputy*" who "*abuse*[d]" their authority and "*misuse*[d]" their "*law enforcement status."* See #1. 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.

4. Discrimination/Racial – A prior Honorary Deputy Sheriffs Association member impersonated a Sheriff's Deputy and used "*racial profiling and intimidation*."

   Board Finding: Pending
   Staff Recommended Finding: Summary Dismissal
   Rationale: Complainant Bernabe alleged misconduct of an "*off-duty*" "*deputy*" who used *"racial profiling and intimidation*." See #1. 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.

26-054/JACK (Summary Dismissal)

1. Misconduct/Medical – Unidentified medical staff failed to follow-up with a medical request for the complainant.

   Board Finding: Pending
   Staff Recommended Finding: Summary Dismissal
   Rationale: On 05-19-26, CLERB received a signed complaint from Toran Jack. Jack alleged, on 09-28-25, he was in-custody at San Diego Central Jail, walking to Court, when he "slipped and fell on [his] back." Jack alleged he sustained an injury to his back, because of the fall. Jack reported a deputy took him to medical. Jack alleged a nurse completed an evaluation and stated Jack would be ordered x-rays once Court was completed. Jack alleged medical staff did not follow-up with the x-rays. Medical staff are non-sworn personnel over whom CLERB has no jurisdiction. 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.

26-057/ALTSMAN (Summary Dismissal)

1. Illegal Search/Seizure – A Carlsbad Police Officer attempted to search Altsman's property on 05-26-26.

   Board Finding: Pending
   Recommended Finding: Summary Dismissal
   Rationale: The Complainant, Dana Altsman, reported on 05-26-26, the officer "*attempted to conduct a warrantless, suspicionless search of my personal belongings*." CLERB lacks jurisdiction over Carlsbad Police Department officers. Pursuant to CLERB Rules and Regulations, 4.1, 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 complainant was referred to, and the complaint forwarded to, the respective agency. The Review Board lacks jurisdiction.

2. Excessive Force – A Carlsbad Police Officer "*grabbed"* Altsman's arm on 05-26-26.

   Board Finding: Pending
   Recommended Finding: Summary Dismissal
   Rationale: Complainant Altsman reported the officer used "*physical force, grabbing my arm, without legal justification*." See Rationale 1. The Review Board lacks jurisdiction.

3. Misconduct/Truthfulness – A Carlsbad Police Officer made a "false" claim.

   Board Finding: Pending
   Recommended Finding: Summary Dismissal
   Rationale: Complainant Altsman reported the officer made a "f*alse claim that I touched him in order to justify a threat of arrest*." See Rationale 1. The Review Board lacks jurisdiction.

26-067/ABE (Summary Dismissal)

1. Misconduct/Procedure – A process server failed to comply with Homeowners Association rules on 05-20-25.

Board Finding: Pending
Staff Recommended Finding: Summary Dismissal
Rationale: Complainant Mayumi Abe reported on 05-20-25, a process server attempted to serve court paperwork to an unknown party in a Rancho Santa Fe community, and “drove recklessly, stalked, trespassed and was belligerent.” The process server was not a SDSO employee. Pursuant to CLERB Rules and Regulations, Section 15, Summary Dismissal, CLERB does not have jurisdiction over the subject matter of the complaint. The Review Board lacks jurisdiction.

End of Report