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The Citizens' Law Enforcement Review Board made the following findings in the closed session portion of its **September 3, 2026**, meeting held in person. **Any changes or additions to staff's recommended findings are bolded in red.** Minutes of the open session portion of this meeting will be available following the Review Board's review and adoption of the minutes at its next meeting. Meeting agendas, minutes, and other information about the Review Board are available upon request or at www.sdcounty.ca.gov/clerb.

CLOSED SESSION

a. CONFERENCE WITH LEGAL COUNSEL

Existing Litigation: Pursuant to Government Code Section 54956.9:

b. PUBLIC EMPLOYEE DISCIPLINE/DISMISSAL/RELEASE

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

DEFINITION OF FINDINGS	
Action Justified	The evidence shows that the alleged act or conduct did occur but was lawful, justified and proper.
Not Sustained	There was <u>insufficient evidence</u> to either prove or disprove the allegation.
Sustained	The evidence supports the allegation and the act or conduct was not justified.
Unfounded	The evidence shows that the alleged act or conduct did not occur.
Summary Dismissal	The Review Board lacks jurisdiction or the complaint clearly lacks merit.

CASES FOR SUMMARY HEARING (9)

ATTENDANCE: Nine (Pintar, Mendleson, Woods, Bisson, Brown, Fasano, Moody, Thomas, Ware)

The CLERB Board voted approve CLERB legal counsel to seek appellate review of the San Diego Superior Court Juvenile Division's Order dated August 19, 2026, regarding the cases listed below. Adverse Party: County of San Diego Probation Department, Juvenile Court litigation relating to juvenile court records and public dissemination.

Fourteen (14) cases:

24-135/DOE 2403, 24-136/DOE 2404, 24-139/DOE 2407, 24-143/DOE 2411, 24-144/DOE 2412,

24-148/DOE 2416, 24-149/DOE 2417, 24-150/DOE 2418, 24-153/DOE 2421, 24-156/DOE 2424

24-158/DOE 2426, 24-160/DOE 2428, 25-014/DOE 2501, 25-047/DOE 2502

AYE: 9

NAY: 0

ALLEGATIONS, BOARD FINDINGS & RATIONALES

24-073/TANNER (Death) **Deferred from 08-06-26**

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

Board Finding: Adopted

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..."

AYE: 7

NAY: 2 (Bisson & Fasano)

24-126/STEWART (Death)

1. Death Investigation/OIS - Deputy Douglas Akers discharged his weapon at Gene Stewart resulting in his death on 09-27-24.

Board Finding: Adopted

Rationale: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. Deputies pulled over a vehicle in National City for violation of window tint. Prior to the vehicle coming to a complete stop, the front passenger, Gene Stewart, ran from the vehicle. Deputies advised dispatch of Stewart's physical description. Detective Akers responded to the area and was advised by a citizen that Stewart was hiding on the passenger side of a parked flatbed tow truck. Detective Akers found the tow truck. A National City Police Corporal arrived to assist Detective Akers. The National City Corporal secured the driver's side of the tow truck, while Detective Akers went to the passenger side to check if Stewart was inside. Detective Akers peered into the closed passenger window and saw Stewart crouched down on the floorboard. Detective Akers knocked on the window and began to identify himself as a Sheriff's Deputy, when Detective Akers heard a gunshot and glass exploded towards Detective Akers face. Detective Akers returned fire and backed up. The door of the tow truck opened and Stewart exited the tow truck with a gun. Stewart took a step, made no statements nor raised his hands. Detective Akers fired his firearm toward Stewart again. Stewart fell to the ground, dropping the gun on the ground next to him. Detective Akers sustained injuries from the glass exploding. A Crime Scene Reconstruction report opined a shot originated from inside the truck as Detective Akers began knocking on the tow truck door. Per SDSO Addendum F Use of Force, *"In situations where lethal force is necessary to defend against an imminent threat of death or serious injury to the deputy or to another person, deputies may use any method of force which is necessary and objectively reasonable to neutralize the threat in defense of human life."* The San Diego County Medical Examiner's Office determined Stewart's manner of death was Homicide and the cause of death was gunshot wounds to the torso and extremities. 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.

AYE: 9

NAY: 0

24-173/RENDON JR. (Death)

1. Death Investigation/LE – Deputies Chalit Caranto, Evan Carey, Thomas Cook, Darryl Patmon, Frank Spinelli Derek Trumbo and Manuel Zamora discharged their firearms at Victor Rendon Jr., resulting in his death on 11-15-24.

Board Finding: Adopted

Conclusion: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 11-15-24 deputies responded to a trespassing call involving Victor Rendon Jr., who entered the reporting party's (RP) residence without authorization. Rendon Jr. was reported to be inside the residence acting erratic, possibly under the influence of drugs, and armed with a firearm. Deputies awaited response from a helicopter and a canine. Deputies were able to safely extricate children while formulating plans to utilize less lethal options to apprehend Rendon Jr. Meanwhile, they issued repeated verbal commands to Rendon Jr. over an extended period. Over that time, deputies observed Rendon Jr. waving a handgun while going in and out of the residence. Rendon Jr. was observed by the deputies and the airborne law enforcement officers demonstrating body movements consistent with being under the influence of drugs and he did not comply with deputies verbal commands. Rendon Jr. opened the front door, raised the handgun, pointed it in the direction of surrounding deputies, at which time six deputies utilized rifles and a handgun to shoot Rendon Jr. Despite life-saving attempts by SDSO and paramedics, Rendon Jr., who had received numerous gunshot wounds, died as a result of the deadly force. A handgun was located immediately next to Rendon Jr.'s body. The Medical Examiner Autopsy Report indicated the cause of death was multiple gunshot wounds, and the manner of death was homicide. The Toxicological Report indicated a detection of ethanol, fentanyl and methamphetamine. Per SDSO De-escalation Policy, Section 11.7, "*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.*" Per SDSO Use of Force Guidelines, Sections 11.9 and 11.11, if a subject is exhibiting life threatening behaviors, deputies' use of firearms to neutralize the subject is permitted. Additionally, per SDSO Use of Firearms/Deadly Force Policy, Section 8.1, "*Deputies shall use deadly force upon another person only when the officer reasonably believes, based on the totality of circumstances, that such force is necessary to either defend against an imminent threat of death or serious bodily injury to the officer or to another person or apprehend a fleeing person for any felony that threatened or resulted in death or serious bodily injury, if the officer reasonably believes that the person will cause death or serious bodily injury to another unless immediately apprehended.*" Per SDSO Aftercare Policy, Section 11.24, "*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. Deputies should continuously monitor a subject until a medical assessment has been provided by a trained medical professional.*" 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.

AYE: 9
NAY: 0

25-119/BARTLETT (Routine)

1. Misconduct/Procedure – Unidentified deputies prevented an Incarcerated Person (IP) from receiving mail.

Board Finding: Not Sustained

Staff Recommended Finding: Not Sustained

Rationale: Complainant William Bartlett alleged an aggrieved IP was denied access to mail while housed at the San Diego Central Jail (SDCJ). The aggrieved alleged he sent mail to CLERB four different times. CLERB has not received physical mail from the aggrieved. When asked why the aggrieved believed his mail was being rejected, the aggrieved stated the mail rejection process was not consistent, and sometimes a letter will be delivered with similar content to a letter which was previously rejected. The aggrieved stated a relative sent books that "*disappeared*," but were tracked through "*Barnes & Noble*." The aggrieved stated the tracking showed the books were delivered to Las Colinas Detention and Reentry Facility (LCDRF) but were not delivered to him at SDCJ. The aggrieved believes the "*corruption*" was at SDCJ. The aggrieved stated the relative reordered the books through "*Amazon*" and they were delivered. The aggrieved confirmed that individuals sending mail have reviewed the SDSO "*Unacceptable Items*" list for sending mail. SDSO documents showed a grievance was submitted by IP the aggrieved related to the missing books. Per the Grievance Report, deputies reviewed the

aggrieved's mail history and there was no record the books were rejected. Deputies contacted the Mail Processing Center (MPC) at LCDRF and confirmed that the tracking for the package showed delivered, however, there were no records of the books being received. The grievance report noted, *"at this time, based on available record, it appears the package may not have reached the facility despite the tracking update. You may contact Barnes and Noble or UPS... for further assistance regarding the delivery status or to request a replacement..."* Per SDO Detention Records, 18 entries were noted that mail sent to the aggrieved was rejected. For each rejection, a reason was noted as required by SDO policy. SDO DSB P&P Section P.3, Incarcerated Person Mail, stated, *"In cases in which incoming mail is withheld for reasons other than drugs/narcotics items... The MPC deputies will enter a 'MREJ' event type into the receiving incarcerated person's JIMS history. The entry will include the name and address of origin and the specific reason the article was not deliverable... The incarcerated person will receive a copy of a Contents Unacceptable Notice (J-320) form. The MPC deputy will identify the article, sender, and disposition on the J-320 form. In cases where incarcerated person mail is not deliverable and placed into the incarcerated person's property, the incarcerated person will receive a copy of the J-320 form and a J-53 form. The notice of appeal rights shall include sufficient information identifying the non-delivered item/mail and the reason(s) why the item(s) pose a threat to detention facility safety and security... Unacceptable books and periodicals will be handled in the same manner as outlined above."* SDO's public website provides a "unacceptable items" list related to sending mail and packages to incarcerated persons. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

2. Misconduct/Procedure – Deputy 1 failed to provide an Incarcerated Person (IP) with cleaning supplies on 08-29-25.

Board Finding: Not Sustained

Staff Recommended Finding: Not Sustained

Rationale: Complainant William Bartlett reported while an aggrieved IP was housed at SDCJ in Housing Module 5D on 08-29-25, a cellmate's "colostomy bag" burst, causing unsanitary conditions in the aggrieved's cell. It was reported on 08-29-25, deputies at San Diego Central Jail (SDCJ) did not provide the aggrieved with supplies to clean his cell after a request was made. SDO documents showed a grievance was submitted by the aggrieved IP related to the incident. A grievance report noted detention staff reviewed CCTV footage around the time alleged by the aggrieved. It was noted in the review that on 08-29-25, at approximately 1:45pm, the door to the aggrieved's cell was opened to be cleaned. Other IPs in the module were provided with cleaning supplies, and they were observed taking them to the aggrieved's cell. It was noted that two safety checks were conducted by deputies while the cell door was opened, and that the aggrieved did not appear to be in distress, make a request for clothing, or that the cell appeared to be dirty. Additionally, Body Worn Camera (BWC) footage from Deputy 1 showed numerous interactions with the aggrieved in the housing module. In one instance, the aggrieved was observed in the dayroom and approached Deputy 1 and a medical staff member. The aggrieved stated to Deputy 1, *"my cellie's covered in urine."* Deputy 1 responded, *"I know, I know, let me take care of it later, bro, alright."* The aggrieved stated to Deputy 1, *"He won't get in the shower. I'm not going to go back in there until I get him out and showered. It's so unsanitary."* Deputy 1 responded, *"I know, but you're going to have to go back in. We'll find... a spot... I can't have you out right now."* The aggrieved stated, *"So you're forcing back into unsanitary conditions."* Deputy 1 responded, *"We're going to get him out, bro. Alright?"* Deputy 1 stated, *"we're going to get the cleaning cart."* stated, *"...at least give me some cleaning supplies so I can scrub the floor..."* Deputy 1 responded, *"I know, but that's why we're going to get the cleaning cart out. Yeah, just take it in for now..."* The aggrieved did not make a request for clothing exchange or comment that his current clothes were soiled. CCTV footage from SDCJ Housing Module 5D was not available. Deputies 1, 2, and 3 provided confidential statements that were taken into consideration for the recommended finding. Per DSB P&P Section L.4 C.2, Housekeeping Plan, Module Cleaning Carts, stated, *"The cleaning carts should also be made available to mainline incarcerated persons prior to the weekly hygiene inspections. Incarcerated persons will be given an opportunity to clean their respective cells as well as the dayrooms and showers. If an incarcerated person is unwilling, unable or if security reasons are documented prohibiting the incarcerated person from having access to the cleaning supplies to clean their cells, the incarcerated person shall be removed from the cell and facility workers will be utilized to clean the cell."* The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

3. Misconduct/Procedure – Deputies 1, 2 and 3 failed to provide an Incarcerated Person (IP) with clean clothes on 08-29-25.

Board Finding: Not Sustained

Staff Recommended Finding: Not Sustained

Rationale: Complainant William Bartlett stated the aggrieved reported that while housed at SDCJ on 08-29-25, his cellmate's "colostomy bag" burst, causing the aggrieved's clothes to become soiled. It was alleged deputies at SDCJ did not provide clean clothes to the aggrieved, after the aggrieved made a request. See Rationale 2. Body Worn Camera footage from Deputy 1 showed numerous interactions with the aggrieved in the housing module. The aggrieved did not make a request for clothing exchange or comment that his current clothes were soiled in the BWC footage reviewed. The aggrieved submitted a grievance related to the incident. A grievance report noted that two safety checks were conducted by deputies, while the cell door was opened, and that the aggrieved did not appear to be in distress, make a request for clothing, or that the cell appeared to be dirty. Additionally, the report noted, *"It is the Detention Services Bureau's mission to provide a safe and humane environment for all our incarcerated individuals. What you described in your grievance is unfortunate and if true, does not meet our overall mission. In my review, it appears the deputies made every attempt to resolve the issue. Moving forward, deputies have already been reminded to afford clean laundry and supplies, when appropriate, to any IP who is in need."* Deputies 1, 2 and 3 provided confidential statements that were taken into consideration for the recommended finding. CCTV footage was unavailable. DSB P&P L.1, Laundry Schedule stated, *"Contaminated Laundry... Deputies will coordinate any unscheduled laundry needs... Contaminated laundry includes clothing, bedding, linen, safety blankets and safety garments that... Are soiled with potentially infectious bodily fluids, such as blood, urine, vomit or feces... Deputies will have an incarcerated person immediately exchange any item which is excessively soiled, is contaminated, or the serviceability/odor presents a safety/health risk or hygiene problem..."* The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

AYE: 9

NAY: 0

25-131/YOUNG (GBI)

1. Use of Force Resulting in Great Bodily Injury – Deputies Dominic Banaga, Christian Del Angel, Alexis Heredia, Zeina Jaouhar and Sean McGillicuddy used force against Robert Young on 10-13-25.

Board Finding: Action Justified

Staff Recommended Finding: Action Justified

Rationale: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 10-13-25, deputies received a radio call of a suspicious subject, Robert Young, who was seated on a hillside, possibly naked and peering into residence windows. The reporting party (RP) called back and advised Young was now at a nearby residence knocking on windows. Deputies Banaga and Del Angel responded and were informed by the RP, *"I stopped him from coming in my house, he was coming at me."* Young ran when he saw deputies. Deputies Banaga and Del Angel pursued Young on foot and yelled out, *"Hey come here, Sheriff's stop!"* and *"Stop running, Sheriff's Stop."* After a short foot pursuit, Deputy Banaga told Young, *"Get down now, get down."* Young faced the deputy, lowered his center of gravity, planted his feet, and raised his clenched fists, chest high. Deputy Del Angel tried to take Young down to the ground and Young tried to punch Deputy Banaga. Deputy Banaga struck Young's upper body and Deputy Del Angel took Young to the ground. Once on the ground, Young tried to stand up, and he was struck again on his face. Young kicked upward and kept his hands tight against the front of his body. Young was told multiple times he was going to get tased. Young did not follow commands, and a drive stun was applied to Young's right lower back. (A "drive stun" is direct contact, firmly pushing "driving" the front of an energized Taser directly into the person.) Young was then placed into handcuffs in a seated position. Additional deputies arrived on scene. Young started *"growling"* and made sounds as if he was going to spit on deputies. Deputies attempted to place a spit sock on Young's head, and he immediately started thrashing his body and kicking. Additional deputies applied downward pressure to Young. Deputies placed Young in a WRAP restraint device. Young sustained a broken nose and was transported to a hospital for treatment before being booked for Resisting an Executive Officer, Criminal Threats and Under the Influence of a Controlled Substance. Deputies Banaga and Del Angel sustained injuries and were medically treated. 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 11.15 Restraint Devices, *“...All restraint devices are temporary restraints used to minimize the risk of injury to deputies and others, prevent or reduce opportunities for self-inflicted injury, prevent escape, and prevent the destruction or concealment of property or evidence. Restraint devices do not totally immobilize a subject. When the restraint device or technique requires multiple deputies, one deputy shall be designated as the safety deputy when feasible. Following the application of a restraint device, subjects shall be placed into a recovery position, or lateral recumbent position, as soon as possible.”* 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.

AYE: 9
NAY: 0

25-137/CATALAN (Routine)

1. Illegal Search & Seizure - Deputies 1, 2, and 3 *unlawfully* detained Catalan on 11-09-25.

Board Finding: Unfounded

Staff Recommended Finding: Unfounded

Rationale: Complainant Lucia Catalan reported, *“...unlawful detention, unlawful search, unlawful seizure of property, improper vehicle stop, violation of due process and misconduct”* on 11-09-25 while she was parked in the George Bailey Detention Facility (GBDF) parking lot. Catalan alleged, *“...a sheriff’s Department patrol vehicle positioned itself directly behind my car, preventing me from leaving...”* Deputies 1, 2, 3 and another deputy were assigned as Visitor and Perimeter Enforcement Deputies (VPED). Per SDO Post Orders, the deputies were responsible for *“vehicle and foot patrol of the complex...contacting any unauthorized or suspicious persons or vehicles... and take appropriate enforcement action as necessary...”* Per CCTV video of the parking lot, three of the deputies stood near SDO vehicles, with the headlights on in the middle of the parking lot, close to the GBDF entrance. Catalan’s vehicle slowly entered the parking lot, past a large white sign stating in capital red letters in both English and Spanish, *“All persons, property, and vehicles are subject to search.”* Catalan turned down one of the aisles closest to the exit and stopped in the driving lane for about nine seconds facing the direction of the deputies. There were no other vehicles on that side of the parking lot, there were many open parking spaces, and no obvious reason Catalan’s vehicle would be stationary in the driving lane facing deputies. Catalan then parked in a parking space near the exit, in the area with no other vehicles and several rows away from the deputies. Deputies 1 and 3, drove their SDO vehicles and parked behind Catalan. Deputy 1 activated the flashing lights on his vehicle. Deputies 2 and another deputy followed in their SDO vehicle and parked behind Deputies 1 and 3. There were no other vehicles in front of or next to Catalan. The parked patrol vehicles did not obstruct forward movement of Catalan’s vehicle or her person. Per SDO DSB P&P I.16 Facility Security-Screenings of Persons Entering a Detention Facility or Support Facility: *“All persons, property, and vehicles entering a Detention Facility are subject to search...While on Detention Facility property, all staff members, and visitors, regardless of rank, classification or affiliation, are subject to search...”* Posted signage warned that *“All persons, property, and vehicles are subject to search.”* Catalan, her passenger, and her vehicle were on jail grounds and therefore subject to search. The investigation clearly established that the allegation is not true.

2. Illegal Search & Seizure - Deputies 1, 2, and 3 *unlawfully* searched Catalan’s vehicle on 11-09-25.

Board Finding: Unfounded

Staff Recommended Finding: Unfounded

Rationale: Catalan reported, "...Without consent, without probable cause, and without a warrant, deputies proceeded to search my vehicle. During the search, they located two work telephones, a broken taser I had previously used during employment in high-risk conditions, and a work utility knife...deputies seized my work telephones..." See Rationale 1. Deputies advised Catalan they were going to search the vehicle because the passenger had "an active 4th waiver" and because they were on jail grounds. Per SDSO DSB P&P I.16 Facility Security-Screenings of Persons Entering a Detention Facility or Support Facility: "All persons, property, and vehicles entering a Detention Facility are subject to search...While on Detention Facility property, all staff members, and visitors, regardless of rank, classification or affiliation, are subject to search..." Posted signage at the entrance of GBDF warned that "All persons, property, and vehicles are subject to search." Consent, probable cause, and a warrant were not required to search the vehicle because Catalan and her passenger were on jail grounds. The investigation clearly established that the allegation is not true.

3. Illegal Search & Seizure – Deputy 2 *unlawfully* seized Catalan's phones.

Board Finding: Unfounded

Staff Recommended Finding: Unfounded

Rationale: Catalan reported, "...deputies seized my work telephones but did not provide: A property receipt, an itemized inventory, any written notice of the seizure or instructions for retrieval..." See Rationales 1 and 2. As Catalan exited her vehicle she had possession of a cell phone. During the search of the vehicle, two additional cell phones were located on the passenger side along with contraband. Catalan's passenger was arrested for possession of a controlled substance on jail grounds, felon on jail-grounds, weapons on jail-grounds, and felon in possession of a stun gun. Deputies attempted to identify the owner of the two additional cell phones but could not establish ownership at the scene. Deputy 2 advised Catalan they would be keeping the phones as evidence. The two cell phones were listed as impounded evidence items in the arrest reports. Per SDSO P&P 6.29 Property Control System: "All property/evidence of any kind impounded or collected must be entered into the property control system using NetRMS...It is the detective's responsibility to attempt to locate and notify property owners..." Ownership of the cell phones was not established at the scene. The impounding of the phones was documented on the arrest report. The investigation clearly established that the allegation is not true.

4. Misconduct/Procedure - Deputy 2 failed to provide a receipt.

Board Finding: Action Justified

Staff Recommended Finding: Action Justified

Rationale: Catalan stated, "Deputies seized my work telephones but did **not** provide: A property receipt, an itemized inventory, any written notice of the seizure, Instructions for retrieval." See Rationales 1, 2 and 3. To verify ownership of the additional phones Deputies 1 and 2 suggested to Catalan she voluntarily unlock the screens using the passcode. Catalan did not unlock the phones, Catalan did not indicate she knew the passcodes and she did not give the passcodes to the deputies so they could unlock the phones. Ownership of the phones could not be established at the scene. Deputy 2 advised Catalan deputies would be keeping the phones as evidence. Catalan left the scene without asking for a receipt or asking about the process to retrieve the phones. The two cell phones were listed as impounded evidence items in the arrest reports. Per SDSO P&P 6.29 Property Control System: "All property/evidence of any kind impounded or collected must be entered into the property control system using NetRMS...It is the detective's responsibility to attempt to locate and notify property owners..." The investigation showed the alleged act did occur but was lawful, justified, and proper.

AYE: 9

NAY: 0

25-141/SORIA (Routine)

1. Misconduct/Procedure – Unidentified deputies kept an Incarcerated Person (IP) in a cell "without a bed or blanket for several days."

Board Finding: Not Sustained

Staff Recommended Finding: Not Sustained

Rationale: Complainant Brianna Soria on behalf of the aggrieved, who was in-custody at San Diego Central Jail. The complainant alleged the aggrieved was booking into custody on 11-25-25 and was kept in “JPM level 2 without a bed or blanket for several days.” SDSO records showed the aggrieved was booked into custody at San Diego Central Jail (SDCJ), on 11-25-25, following an arrest made by San Diego Police Department (SDPD). CLERB staff attempted to obtain additional information from the aggrieved regarding the allegation, without success. Per DSB P&P Section L.1, Laundry Schedule, “A. *The standard issue of bedding and linen shall include: 1. One mattress 2. Two white towels 3. Two cotton/wool blankets* B. *Exceptions may be made if special circumstances exist (e.g., medical accommodation as determined by medical staff, or facility specific bedding as determined by the facility commander).* C. *Two towels shall be issued to each incarcerated person and will be exchanged once a week. D. Two blankets shall be issued to each incarcerated person. One of the blankets will be an alternative to a sheet. The facility commander may authorize the issuance of a third blanket if temperatures warrant. If issued, the third blankets should be distributed beginning the week after Thanksgiving Day and should be recovered the week after Memorial Day. However, in the event of an emergency, regardless of the time or season, the facility commander has the discretion to issue or retrieve the third blanket based on department needs. One blanket shall be exchanged on a bi-weekly basis (refer to facility green sheets for blanket exchange schedules).* E. *A Jail Information Management System (JIMS) “Laundry Exchange” log entry will be made to record each exchange. The type of exchange (e.g. “Blankets”) will be noted in the “Description” field of the log entry. In the event an item is unavailable for the laundry exchange, the deputy of the affected area shall document which item was not exchanged in the “Notes” section of the log entry.*” The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

2. Misconduct/Procedure – Unidentified deputies did not provide medical attention for an IP.

Board Finding: Not Sustained

Staff Recommended Finding: Not Sustained

Rationale: The complainant alleged “[the aggrieved] *fell twice*” in a cell and sustained an injury. The complainant alleged, “[the aggrieved] *called ‘mandown’ but after getting helped twice, he was told he was exaggerating and received no immediate medical attention.*” SDSO records showed on 11-27-25, a Medical Inmate Status Report (ISR) was entered by SDCJ staff which noted the aggrieved was contacted by SDCJ staff after the aggrieved reported they fell in the cell. Per the report, the aggrieved was evaluated by medical staff. CLERB was unable to access the aggrieved’s medical records without a signed authorization. CLERB attempted to obtain additional information from the aggrieved regarding the allegation, without success. Per DSB P&P Section M.1, Access to Care – “*Any incarcerated person in the custody of the San Diego Sheriff shall have quality and timely access to care for their medical, dental and mental health needs. The Responsible Health Authority (RHA) shall identify and eliminate any unreasonable barriers, intentional or unintentional, to inmates receiving health care.*” The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

3. Misconduct/Procedure – Unidentified deputies denied an IP toilet paper.

Board Finding: Not Sustained

Staff Recommended Finding: Not Sustained

Rationale: The complainant alleged, “[the aggrieved] *was denied toilet paper...*” CLERB staff attempted to obtain additional information from the aggrieved regarding the allegation, without success. Per DSB P&P Section L.4, Housekeeping Plan, “...Each facility will establish a written housekeeping plan for all areas of the facility... *The housekeeping plan will include, but not be limited to: areas to be cleaned; those responsible for the cleaning; who supervises the cleaners; how supplies and materials are ordered and distributed...*” The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

4. Misconduct/Discourtesy – An unidentified deputy made an inappropriate comment.

Board Finding: Not Sustained

Staff Recommended Finding: Not Sustained

Rationale: The complainant alleged, “*A detective made an inappropriate comment about our deceased mother.*” CLERB staff attempted to obtain additional information from the aggrieved regarding the allegation, without success. SDSO P&P, Section 2.22, Courtesy, “*Employees shall be courteous to the public and fellow employees. They shall be tactful in the performance of their duties, shall control their tempers, exercise patience and discretion*

even in the face of extreme provocation. Coarse, profane, or violent language is generally prohibited. Employees shall not use insolent language or gestures in the performance of their duties.” The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

5. Misconduct/Medical – Unidentified health care staff did not provide medical attention to an IP.

Board Finding: Summary Dismissal

Staff Recommended Finding: Summary Dismissal

Rationale: The complainant alleged, “on [11-30-25], *medical staff told me they already treated him, but [the aggrieved] reported ongoing pain and difficulty walking, which suggests inadequate medical care.*” CLERB Rules & Regulations Section 4.1 Complaints: Authority. “*Pursuant to the Ordinance, CLERB shall have authority to receive, review, investigate, and report on Complaints filed against peace officers or custodial officers employed by the County in the Sheriff’s Office...*” The Review Board lacks jurisdiction.

AYE: 9

NAY: 0

26-022/SILVER (Routine)

1. Misconduct/Procedure - Deputy 1 “*left*” the aggrieved in the recreation yard overnight on 01-08-26.

Board Finding: Unfounded

Staff Recommended Finding: Unfounded

Rationale: Complainant Eden Silver alleged on 01-08-26, “*While at George Bailey, (the aggrieved) was left outside at night in freezing rain by (a deputy) and was assaulted by the same individuals who have harmed him there previously. He was even shown a weapon they will use to kill him. He suffered a bloody nose and a limp as a result. He was cleaned up before appearing in court and was deprived of sleep after spending the night in fear for his safety.*” The aggrieved’s Inmate History Report documented that he was transferred from SDCJ to GBDF on 01-08-26 and housed in Area 1, Housing Unit C. Records confirmed that one of the two IPs identified in the prior Keep Separate documentation was transferred to state prison before the aggrieved transferred to GBDF. The second IP was not housed in Housing Unit C with the aggrieved. At approximately 11:35pm, a deputy’s BWC footage captured the aggrieved inside Housing Unit C where he confirmed his identity to the deputy. At approximately 11:39pm, the footage showed deputies escorting two other IPs out of the unit to the recreation yard. Neither individual was the aggrieved. CCTV footage showed the two IPs entered the yard and later returning to the housing unit. The footage did not show the aggrieved entering or being placed in the recreation yard during the remainder of the night. The evidence showed that neither IP identified in the prior Keep Separate documentation was housed with the aggrieved during the relevant period. The Watch Commander’s Log and medical records contained no documentation of an alleged assault, threat, bloody nose, or limp. SDSO DSB P&P Section R.1, states “*The Jail Population Management Unit (JPMU) will conduct classification assessments, assign individuals a classification, and assign housing for all incarcerated persons. An incarcerated person’s initial classification is determined by their original booking charges, criminal history information, medical and psychiatric issues or additional special conditions, and information obtained from the incarcerated person interview. The incarcerated person will be assigned to the most appropriate housing location based on their classification designation.*” SDSO DSB P&P Section R.3, states, “*Miscellaneous modifiers are used to alert staff of legal considerations, or potential enemies in custody, prior to the release or transfer an incarcerated person. The modifiers are added using the incarcerated person classification code in the ‘Hazards & Instructions’ section of the Evaluation Update screen... Code Explanation: KS (Keep Separate, has enemies in JIMS).*” The investigation clearly established that the allegation is not true.

AYE: 9

NAY: 0

26-056/BAILEY (Routine)

1. Misconduct/Procedure - Deputy 1 “*improperly*” moved an Incarcerated Person (IP) on 05-26-26.

Board Finding: Unfounded

Staff Recommended Finding: Unfounded

Rationale: Per Tiauna Bailey's complaint for the aggrieved, *"I repeatedly asked staff if I could return to my cell, but I was told that I would not be going back to the cell I was originally assigned to. I was never given a valid explanation for why I was being moved."* Bailey was referring to the aggrieved's change of cell assignment following their visit to the medical unit on 05-26-26. In the 05-17-26 Incident Report, Rules Violation Report, Disciplinary Separation was ordered for three IPs, including the aggrieved. On 05-26-26, Deputy 1 communicated with the aggrieved, asking him *"Why you down here now?"* Deputy 1 further stated while directing his attention towards the cell occupied by the aggrieved and another inmate, *"We got (the aggrieved), you're in 17, who did you switch with, Bro?"* The aggrieved replied, naming the other inmate, to which Deputy 1 stated, *"You guys can't be in the same cell."* The aggrieved responded, *"Yes, we can."* Deputy 1 replied, *"No, you can't."* The aggrieved, *"They made the move."* Deputy 1, *"I told you, they did it wrong."* Deputy 1 logged the aggrieved's cell assignment changes and moves in the Jail Information Management System (JIMS). Per P&P Section I.53, Movement of Incarcerated Persons: *"Upon determination of the movement of an incarcerated person(s) (e.g., court appearance, clinic, visit/interview, etc.), the deputy will notify the affected person(s) of the pending action. All incarcerated persons leaving/returning to the housing unit shall be appropriately logged in the Jail Information Management System (JIMS). Additionally, deputies shall confirm the incarcerated person's identity against their wristband and conduct a pat-down search for contraband of each person leaving from and returning to their assigned housing area...To ensure a smooth and efficient operation, it will be necessary to coordinate all movement of incarcerated persons with detention staff who will be directly involved (i.e. control deputy, housing deputy(s), rovers, detention information assistants, court deputy, etc.). Professional staff and sworn staff must cooperate in order to avoid confusion resulting from a breakdown in communication."* The investigation clearly established that the allegation is not true.

2. Misconduct/Procedure – Deputy 1 delayed in providing an IP access to medical care on 05-26-26.

Board Finding: Unfounded

Staff Recommended Finding: Unfounded

Rationale: Per Bailey's complaint for the aggrieved, *"I came out of my cell voluntarily to seek medical attention because I was experiencing an anxiety attack and heart-related symptoms. Instead of receiving proper medical care, I was placed in a holding tank against my will for approximately two hours."* *"He repeatedly requested to go to medical, and when he was finally taken, he was allegedly placed in a cage for an excessive amount of time."* When the aggrieved was told by Deputy 1, he could not be in the same cell as another IP, the aggrieved stated, *"Neither one of us has medical issues...can you take me to the hospital so I can get myself checked out?"* Deputy 1 stated, *"Yeah, let's go."* At that time, the aggrieved did not make a statement about or display distress of a current medical or health emergency. Deputy 1 took the aggrieved to a side holding cell and told him, *"You are going to go into this side cell now until I finish razors."* Forty-eight minutes and 46 seconds elapsed from the time Deputy 1 placed and removed the aggrieved from the temporary holding cell. While removing the aggrieved from the cell, he asked Deputy 1 if he could go to medical, stating, *"I think I'm having a heart attack."* Deputy 1 asked him, *"Does your chest hurt?"* The aggrieved replied, *"Yes."* Deputy 1 stated, *"Okay, let's go,"* and took the IP to the medical unit for evaluation by a registered nurse. Noted in the complaint Bailey filed for the aggrieved, *"His requests were ignored multiple times to the point that he felt forced to declare a 'man down' just to receive medical attention."* At the medical unit, the nurse conducted medical tests on the IP and then advised there was not a medical or health issue and released the IP to Deputy 1. Per DSB P&P, Section M.1 Sick Call, *"Incarcerated persons shall have access to appropriate medical and mental health services on a daily basis. Sick call procedures are explained by health staff to each newly arrested incarcerated person at the time of receiving screening. Procedure 1.B, Incarcerated persons in need of urgent medical attention shall be immediately referred to health staff."* The investigation clearly established that the allegation is not true.

3. Misconduct/Procedure – Deputy 1 failed to adhere to an IP's classification on 05-26-26.

Board Finding: Unfounded

Staff Recommended Finding: Unfounded

Rationale: Per Bailey's complaint for the aggrieved, *"Staff informed me that I was being moved to B Pod, even though that was not the classification area where I was supposed to be housed. Being moved there placed my safety at risk."* *"When he asked to return to his cell, he was told to 'shut the fuck up' and informed that he would not be returning to his cell. His requests were ignored multiple times to the point that he felt forced to declare a 'man down' just to receive medical attention. After this incident, he still was not returned to his original cell and*

was instead placed back into a cage where he states he continued to be antagonized.” Upon the aggrieved’s initial booking on 04-20-2026, the IP was classified as a Level 5 inmate and remained classified as a Level 5 inmate throughout incarceration. On 05-26-26, the aggrieved was moved from SDCJ, Area 5, Housing Unit A, Cell 17 to SDCJ, Area 5, Housing Unit B, Cell 03, neither of which housed IPs with a classification higher than a Level 5. Per SDSO DSB P&P Section R.1, Incarcerated Persons Classification, “The purpose of the incarcerated population Classification System is to screen, assess and house incarcerated persons in a manner that will protect the safety of the community, staff, and other incarcerated persons. It also assists detention managers and staff in making sound decisions regarding management of the jail population. Proper classification of incarcerated persons promotes impartial and consistent classification evaluations and helps provide legal protection to staff by establishing reasonable, objective, and defensible safety practices. The Jail Population Management Unit (JPMU) will conduct classification assessments, assign individuals a classification, and assign housing for all incarcerated persons. An incarcerated person’s initial classification is determined by their original booking charges, criminal history information, medical and psychiatric issues or additional special conditions, and information obtained from the incarcerated person interview. The incarcerated person will be assigned to the most appropriate housing location based on their classification designation. Housing Assignments: Incarcerated persons with custody levels 1, 2, or 3 can be housed together. Levels 4 and 5 can be housed together. Level 6 incarcerated persons will be housed in Administrative Separation.” The investigation clearly established that the allegation is not true.

4. Misconduct/Procedure – Deputy 1 failed to activate their Body Worn Camera (BWC) on 05-26-26.

Board Finding: Unfounded

Staff Recommended Finding: Unfounded

Rationale: Per Bailey’s complaint for the aggrieved, “He also informed me that during these interactions, the officers’ body cameras were turned off.” It was noted Deputy 1 had his BWC activated when he approached the aggrieved in his assigned cell. Deputy 1’s BWC stayed activated throughout his contact with the aggrieved, to include when he told him he could not remain in the current cell with a specific inmate. Deputy 1’s BWC was activated when he told the aggrieved, “You guys can’t be in the same cell,” referring to the aggrieved and the other inmate. Deputy 1 had his BWC activated when he moved the aggrieved to a holding cell, and then 48 minutes and 46 seconds later, Deputy 1’s BWC was activated when he moved the aggrieved from the holding cell to the medical unit. Lastly, when Deputy 1 moved the aggrieved from the medical unit to his new cell, Deputy 1’s BWC was activated. Per SDSO DSB P&P Section I.20, Supplemental Guidelines for Detentions Body Worn Cameras (BWC): “Deputies shall activate their BWCs in accordance with San Diego Sheriff’s Office Body Worn Camera Policy and Procedure 6.131, as well as whenever possible, prior to engaging in and for the entire duration of the performance of the following duties: 1. Any movements or escorts of incarcerated persons from one area to another (cell movements, between housing modules, holding cells, visitation, courts, from intake or to final release, etc....” The investigation clearly established that the allegation is not true.

AYE: 9
NAY: 0

Adjourned 9:43 pm

End of Report