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County of San Diego

CITIZENS' LAW ENFORCEMENT REVIEW BOARD

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The Citizens' Law Enforcement Review Board made the following findings in the closed session portion of its **November 5, 2026**, meeting held in person. **Any changes or additions to staff's recommended findings are bolded in red.** Minutes of the open session portion of this meeting will be available following the Review Board's review and adoption of the minutes at its next meeting. Meeting agendas, minutes, and other information about the Review Board are available upon request or at www.sdcounty.ca.gov/clerb.

CLOSED SESSION

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

AUTHORITY AND JURISDICTION	
JURISDICTION CATEGORIES	**AGENCY INVOLVEMENT**
Death (4.4.a & 4.1.i)	SDSO – Detention Services
Discharge of Firearm (4.4.b & 4.1.c)	SDSO – Law Enforcement Services
Use of Force Resulting in GBI (4.4.c)	SDSO – Court Services
Use of Force at Protest (4.4.d)	SDSO – Medical Services
Procedure (2.13.a & 4.2.a)	Probation – Institutions Services
Violation of Law (2.13.b & 4.1.h)	Probation – Field Services
Use of Force (4.1.a)	
Discrimination (4.1.b)	
Sexual Harassment (4.1.b)	
Search or Seizure (4.1.d)	
Arrest (4.1.e)	
Reporting (4.1.f)	
Criminal Conduct (4.1.g)	
Improper or Unbecoming Conduct (2.13.c)	
Standard of Care (2.13.d & 3.9.j)	
Error or Omission (2.13.d)	

DEFINITION OF FINDINGS	
Action Justified	The investigation proved the alleged act did occur but was lawful, justified, and proper.
Not Sustained	The investigation failed to prove or disprove the allegation by a preponderance of evidence.
Sustained	The investigation proved the allegation by a preponderance of evidence.
Unfounded	The investigation proved the allegation is not true by a preponderance of evidence.
Summary Dismissal	The Review Board lacks jurisdiction, cooperation, protected evidence, or the allegation clearly lacks merit.
Preponderance	**Evidence that has more convincing force than that opposed to it.**

"MISCONDUCT" DEFINED
"Misconduct" is defined to mean and include any alleged improper or illegal acts, omissions, or decisions directly affecting the person or property of a specific person arising out of the performance of the duties of peace officers, employees or custodial officers employed by the County in the Sheriff's Office or the Probation Department including employee and contracted Health Care Providers by reason of a. An alleged violation of any general, standing, or special orders or guidelines of the Sheriff's Office or the Probation Department. b. An alleged violation of any state or federal law. c. Any act otherwise evidencing improper or unbecoming conduct by a peace officer, employees or custodial officers employed by the County in the Sheriff's Office or the Probation Department including employees and contracted Health Care Providers. d. For purposes of Heath Care Providers, a deviation from standard of care, error, or omission related to any health service provided. (CLERB R&R, 2.13)

CASES FOR SUMMARY HEARING (19)

ATTENDANCE: Pintar, Mendleson, Woods, Brown, Dumas, Fasano, Moody, Thomas (8)

Findings language reflects the Rules & Regulations which went into effect on October 30, 2026.

25-103/CURREN

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: Adopted
   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: Unfounded
   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 investigation proved the allegation is not true by a preponderance of evidence.

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

   Board Finding: Unfounded
   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 investigation proved the allegation is not true by a preponderance of evidence.

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

   Board Finding: Not Sustained
   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 prove or disprove the allegation by a preponderance.

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
   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: Unfounded
   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 proved the allegation is not true by a preponderance of evidence.

AYE: 7 (Pintar, Woods, Brown, Dumas, Fasano, Moody, Thomas)
NAY: 0
ABSTAIN: 1 (Mendelson)

25-112/HAYES

1. Use of Force Resulting in Great Bodily Injury – Deputies Susana Arredondo and Andrea Blas used force against Incarcerated Person (IP) Zabel Jenna Hayes on 08-12-25.

   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. While housed in MOB (Medical Observation Bed), deputies asked IP Hayes to move into a neighboring cell. Hayes resisted by telling deputies to, *"Get the fuck away from me"* as IP Hayes extended her right hand toward Deputy Arredondo. IP Hayes walked out of the cell but walked in the opposite direction. IP Hayes resisted repeated instructions to go into the new cell. Deputy Blas had her Taser out and IP Hayes yelled for deputies to *"tase*" her. IP Hayes stepped toward Deputy Arredondo who took two steps backward but was unable to reposition any further due to a wall. Deputy Arredondo held out her arm to create distance from IP Hayes. IP Hayes slapped Deputy Arredondo's hand then lunged toward Deputy Blas causing the Taser to fall to the ground. Deputy Arredondo took IP Hayes to the ground where both deputies secured IP Hayes in handcuffs. IP Hayes sustained an injury and medical personnel provided care. The following day, IP Hayes was referred to the hospital for follow-up treatment for the injury. Per SDSO P&P 6.48 Physical Force, "*It shall be the policy of this Office whenever any Deputy Sheriff of this Office, while in the performance of his/her official law enforcement duties, deems it necessary to utilize any degree of physical force shall only be that which the Deputy Sheriff believes necessary and objectively reasonable to effect the arrest, prevent escape or overcome resistance (per 835(a) PC*)…" Per SDSO P&P 11.13 Personal Body Weapons, "*Personal body weapons may be used to strike available targets to control an actively resistant or assaultive subject. Personal body weapons may include hands, fists, arms, elbows, legs, knees, feet, and head. Some strikes may result in serious bodily injury and are generally used against a higher level of subject resistance. Some strikes may be used to facilitate a takedown or gain control of an actively resistant subject. These types of strikes are not intended, nor likely to cause serious bodily injury."* The investigation proved the alleged act did occur but was lawful, justified, and proper.

2. Misconduct/Procedure – Deputy 1 failed to activate their Body Worn Camera (BWC) on 08-12-25.

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: See Rationale 1. Deputy 1 contacted IP Hayes to "*escort"* IP Hayes from one cell to another. Deputy 1 did not have their BWC activated during the initial contact with IP Hayes. The BWC was turned on after force was used and IP Hayes was on the ground. Deputy 1 made supervisory notifications about the BWC not being activated during the initial contact. Per I.20 Supplemental Guidelines for Detentions: Body Worn Camera, "…*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:…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.)…e) Contacting an incarcerated person who is inside of their cell, including conversations through a window, door, or food flap*." The investigation proved the allegation by a preponderance of evidence.

AYE: 8 (Pintar, Mendleson, Woods, Brown, Dumas, Fasano, Moody, Thomas)
NAY: 0

25-116/SMITH

1. Death Investigation/Incarcerated Person (Natural) – Incarcerated Person (IP) Eugene Smith died while in the custody of the San Diego Sheriff's Office (SDSO) on 10-01-25.

   Board Finding: Adopted
   Conclusion: This case was reviewed in accordance with CLERB Rules & Regulation Section 4, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. Eugene Smith was arrested by deputies for public intoxication on 09-29-25 around 7:40pm and transported to San Diego Central Jail (SDCJ). Smith was

evaluated by jail medical personnel and cleared for admittance into SDCJ. Smith was classified as a book and release, signifying he was a temporary Incarcerated Person (IP) and would not be placed into housing. Deputies conducted a body scan of Smith and placed him into a sobriety cell on 09-30-25 at about 9:16pm. Smith remained in the sobriety cell for over 29 hours until 10-01-25 at about 2:30am. While in the sobriety cell, Smith alternated between sitting, sleeping, walking, eating, and using the restroom. While Smith was in the sobriety cell, deputies filled out the required observation log and documented required 6-hour checks of Smith four times. At about 2:30am, deputies determined Smith would be moved out of the sobering cell, "*Due to IP Smith's cooperation and conversations with deputies, it was determined that he would be fit to continue with the booking process."* Smith walked out of the sobering cell without assistance and without restraints. Deputies attempted to escort Smith into a medical evaluation cell for a medical assessment, but he refused while attempting to pull away from deputies. Deputies secured Smith in handcuffs and had a nurse respond to the hallway for a medical evaluation and vitals check. Deputies placed Smith into waist chains and escorted him to the fingerprinting area. It took deputies about 11 minutes to fingerprint Smith as he alternated between being cooperative and resistive. At the conclusion of fingerprinting, deputies placed Smith into a temporary holding cell at about 2:52am. Smith remained in the temporary holding cell for about 21 hours until he was discovered not breathing. While Smith was in the temporary holding cell, deputies performed required safety checks, food deliveries, a soft count and a hard count. At approximately 11:55pm, deputies, who were assigned to move IPs from a nearby cell, smelled a strong odor of feces emanating from Smith's cell. Deputies entered the cell, observed dark feces on the ground near Smith, checked his pulse and determined he was not breathing. Deputies immediately began CPR, requested medical personnel and activation of 911. Medical personnel arrived about one minute later and took over CPR and the application of an AED. Paramedics from San Diego Fire arrived about eleven minutes after they were requested and assumed lifesaving measures. Smith was transported to UCSD where lifesaving measures continued until he was pronounced deceased. Smith was in SDSO custody for approximately 52 hours. The San Diego Medical Examiner determined, "*the cause of death is acute peritonitis due to chronic pancreatitis with ruptured pancreatic pseudocyst. With hypertensive and atherosclerotic cardiovascular disease and alcohol used disorder as contributing conditions, and the manner of death is natural.*" Pursuant to CLERB Rules and Regulations Section 10.1, 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 10.3.

2. Misconduct/Procedure – Deputy 9 failed to ensure deputies documented a 6-hour check of IP Smith while in the sobering cell.

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: See Rationale 1. Deputy redacted conducted a 6-hour check of Smith while he was in the sobering cell on 09-30-25 at about 3:00pm and documented the interaction on an Incident Status Report. Deputy redacted determined Smith was not ready for removal from the sobering cell writing, "*I asked Smith to speak with me at the cell door. Smith blankly stared at me and mumbled slurred speech in response to me when I asked him questions. Smith could not understand my commands and could not properly answer my questions. Smith still is showing signs of intoxication and will remain in Sobering Cell 4 until it is safe and acceptable to continue with the booking process. Next update at 2316 hour*s." The next 6-hour check of Smith occurred by deputies at about 2:29am. This was about 11.5 hours after the previous check. Per DSB J.2, Sobering Cells: "*The need for continued retention must be documented by sworn staff in a JIMS incident report, utilizing the "SOU" (sobering cell update) incident code every six hours until the incarcerated person is cleared from the sobering cell*." Per SDCJ Green Sheet J.2.C.1, Sobering Cells, "*A Jail Information Management System (JIMS) entry will be made for the placement using Sobering Cell Placement report. Additionally, any six-hour updates will be entered in JIMS under Sobering Cell Update. All 2nd floor deputies (search/medical, medical screening and release) will be responsible for these entries.*" Deputy 9 and Sergeant redacted provided confidential statements during CLERB's investigation that were taken into consideration. The investigation proved the allegation by a preponderance of evidence.

3. Misconduct/Procedure – Deputy 4 failed to attach IP Smith's identification wristband to his wrist.

   Board Finding: Sustained
   Staff Recommended Finding: Sustained

Rationale: See Rationale 1. On ~~10-02-25~~ **10-01-25** at approximately 2:29am, Smith was removed from the sobering cell, medically evaluated, fingerprinted and placed into a holding cell. It took deputies approximately eleven minutes to fingerprint Smith as he alternated between resistive and cooperative. At the conclusion of the fingerprinting, Deputy 4 grabbed Smith's paperwork and wristband rather than affixing it to him and carried it with him as they escorted Smith to the holding cell. When they reached the holding cell, Deputy 4 was the primary deputy communicating with Smith telling him, "*I'm gonna take these* (waist chains) *off ok*" when they placed him into the holding cell. Deputy 8 removed the waist chains with the assistance of Deputy 7 while Deputy 4 communicated with Smith. Per BWC, after removing the waist chains, the deputies exited the cell. Deputy 5 closed the cell door and handed Smith's paperwork and wristband to Deputy 4. The wristband was never affixed to Smith and instead placed on the cell door in the food flap. At no time during his incarceration was Smith fitted with his identification wristband. DSB Section I.47, Wristbands said, "*An identifying wristband will be secured on the incarcerated person's left wrist (except in case of amputation, prosthesis or cast).*" Deputies 5, 4, 8, and 7 were all present and assisted when Smith was fingerprinted and placed into the holding cell. Deputy 4 was the primary deputy communicating with Smith and was last seen holding the wristband after Smith was secured in the holding cell. Deputies 5, 4, 7, and 8 provided confidential statements during CLERB's investigation that were taken into consideration. The investigation proved the allegation by a preponderance of evidence.

AYE: 6 (Pintar, Woods, Brown, Dumas, Fasano, Thomas)
NAY: 2 (Mendelson, Moody)

4. Misconduct/Procedure – Deputies 1, 3, and redacted failed to follow policy during a Hard Count of IP Smith.

   Board Finding: Not Sustained
   Staff Recommended Finding: Not Sustained
   Rationale: See Rationale 1. On 10-01-25 at about 9:43pm, Deputies 1, 3, and redacted conducted a Hard Count of the 2nd floor holding cells. During their checks, deputies entered cells or verbally spoke with IP's verifying their identity by checking their wristbands. As they approached Smith's cell, his purple wristband was seen sticking out of the food flap. As Deputy 1 reached the door and grabbed the wristband, he made the comment, "*geez*." Deputy 1 called out, "*Smith, Eugene*" and placed the wristband back into the food flap. Deputy 3 said, "*oh man*" as he walked up to the cell. Deputy 1 shined his flashlight into the cell and Deputy 3 made the comment, "*Oh smell.*" Despite those exclamations, neither deputy attempted to communicate with Smith other than calling out his name nor did they enter the cell to verify his condition. DSB Section I.43 Count Procedures said, "*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 pr 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.)*." Deputies 1 and 3 provided confidential statements during CLERB's investigation that were taken into consideration. The investigation failed to prove or disprove the allegation by a preponderance of evidence.

5. Misconduct/Procedure – Deputy 6 failed to conduct a safety check of IP Smith

   Board Finding: Sustained
   Staff Recommended Finding: Sustained
   Rationale: See Rationale 1. At about 11:25pm, Deputy 6 was assigned to perform safety checks of the 2nd floor holding cells. During his checks, Deputy 6 was observed on BWC and CCTV footage holding and looking at his cellphone during a portion of the checks. When he reached Smith's cell, Deputy 6 was heard audibly sighing and saying, "*Jesus Christ*" as he was looking into Smith's cell. Deputy 6 remained at Smith's cell for about eight seconds and then continued with his checks without attempting to make verbal contact with Smith. Deputy 6 told SDSO investigators, "*I smelled something was off but I didn't know what cell it was during the last few cells I was walking by and what I saw was an IP on the ground but laying there I saw his chest rise and fall and I stayed there to see if that was where the smell was coming from I believe that I thought that was the correct cell and that's why I stayed there to see if there was anything else wrong, I didn't see anything else and I continued with my walk*." Thirty minutes later, at about 11:55pm, deputies who were assigned to move IPs in a nearby cell smelled a strong odor of feces in the hallway and immediately determined it was coming from Smith's cell. The deputies went to Smith's cell and as they looked inside a deputy exclaimed, "*Oh my god*" and "*Please be alive.*" The deputies entered Smith's cell after he failed to respond to their calls. When they entered his cell, they discovered he was not breathing and began rendering

emergency aid. A deputy described to SDSO investigators as observing dark colored feces that, "*didn't look like normal feces*" and said, "*there's feces everywhere*" when describing the condition of the cell. Per BWC, there were dark, dried feces smeared on the floor around Smith's torso and legs. DSB P&P I.64 Safety Checks said, "*Sworn staff shall 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.*" Deputy 6 provided a confidential statement that was taken into consideration. The investigation proved the allegation by a preponderance of evidence.

6. Death Investigation/Health Care Providers – Incarcerated Person (IP) Eugene Smith died while incarcerated at the San Diego Central Jail (SDCJ) on 10-01-25

   Board Finding: Adopted
   Conclusion: This case was reviewed in accordance with CLERB Rules & Regulations Section 4.4, Complaint Not Required: Jurisdiction with Respect to Specified Incidents; 6.1(h) Consultation with subject matter experts; and 3.9(j) Adequate Staffing. See Rationale 1 for details. Per the medical review report, Smith was evaluated by jail medical personnel and cleared for admittance into SDCJ. Medical staff completed nine evaluations of Smith while he was in the sobering cell, including the placement and release interactions. Provider rounding on individuals in a sobering cell was completed only once, not once per shift. MSD A.3, Medically Supervised Withdrawal and Treatment said, "*III. B Rounded on by a provider and psychiatrist/psych NP team once per shift for a maximum of three rounds*." However, individual responsibility for Provider rounding could not be determined based on Provider staffing rosters. Medical staffing rosters revealed numerous vacancies each day of Smith's incarceration. The medical response to Smith's emergency was timely once notified of the incident. MSD M.1 Emergency Response said, "*Upon notification or observation of a medical emergency health staff will respond to the scene with emergency equipment. If there is a physician/RNP in the facility they will respond to the scene with health staff*." Pursuant to CLERB Rules and Regulations Section 10.1, 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 10.3.

7. Misconduct/Procedure – HCP 10 failed to complete a proper medical assessment of IP Smith at intake.

   Board Finding: Sustained
   Expert Recommended Finding: Sustained
   Rational: See Rationales 1 & 6. Smith was medically evaluated for intake on 09-29-25 at about 9:00pm after his arrest for Public Intoxication. Per the medical review report, the general medical assessment and mental health screening were incomplete. Smith's vital signs indicated tachycardia and his 113lb weight was concerning as it likely indicated an undernourished state consistent with alcohol use disorder. Smith's blood pressure was elevated and worthy of a follow-up investigation. Per BWC, it appeared Smith was in pain and complained of bleeding. There was no clarification by HCP 10 regarding Smith's apparent pain and HCP 10 missed an opportunity to clarify if Smith was complaining of a GI bleed, instead telling him, "*You're not bleeding at all, you're not*." No mental health screening questions were answered by Smith. The intake clearance, medical, and mental health screening forms were confusing and offered little opportunity to explain findings or their absence. Smith presented an altered mental status, yet it appeared the focus of the reason for his condition was based only on the arresting deputy's interpretation that Smith was intoxicated. While that may have been true, other apparent and potential co-occurring illnesses remain that HCP 10 should have been alert to, yet none were listed as considered. Smith should have been screened and cleared before admission to jail custody. Smith was unable to answer questions and appeared to have comorbid mental health and medical concerns that were dismissed as "*under the influence*" and should have been transferred to a licensed medical facility and/or the jail infirmary (Medical Observation Bed). Per MSD E.2.1 Receiving Screening, "*A. A registered nurse (RN) will perform comprehensive clinical assessment at the time of booking prior to acceptance into the detention facility. Medical clearance into the detention facility is incumbent upon the individuals condition at the time of assessment. C. Individuals exhibiting signs of excited delirium, disorganization of thoughts, altered mental status and confusion will require medical and possible psychiatric evaluation prior to being accepted into the detention facility*." The investigation proved the allegation by a preponderance of evidence.

AYE: 7 (Pintar, Mendleson, Woods, Brown, Dumas, Moody, Thomas)
NAY: 1 (Fasano)

25-129/DIAZ & PERSSON

1. Illegal Search & Seizure – Deputy 2 entered Persson's property.

   Board Finding: Action Justified
   Staff Recommended Finding: Action Justified
   Rationale: Complainant Abagail Persson reported, *"I have the right to be free from seizure in the curtilage of my own home."* Diaz wrote, *"*Deputy 2 *had no reason to enter the west part of my property. There were no exigent circumstances to give him the right to enter the curtilage of my home." "There was no crime occurring inside my house or on my porch".* On 05-13-25, deputies were involved in a pursuit that ended on the north side of the complainant's duplex. The suspected vehicle from that pursuit stopped in the driveway of the side yard. Both occupants exited the vehicle and the driver (the aggrieved) fled on foot further into the yard of the complainant's duplex. Deputies contacted the aggrieved and a use of force occurred. Additional deputies arrived to assist with the incident, including Deputy 2. Upon Deputy 2 arrival he was alerted by another deputy that *"a female"* left one of the duplex's entrances and entered the next entrance. The aggrieved's incident was still active, and Deputy 2 observed two females exit the second entrance. He told them, *"Stay right there, don't be coming in and out of the house*." Deputy 2 entered the picket fence on the front yard and addressed both females again telling them, *"That's an officer safety issue, you need to stop doing that."* Terry v Ohio "knock and talk" exception states, *"Officers may walk up standard, direct walkways, driveways, or paths to the front door to speak with the occupant."* Per the California Peace Officers Legal Sourcebook (CPOLS), "*Typically, it is proper for you to access a person's driveway or to view areas and objects from that location, and the fact the driveway is within the "curtilage" is not, by itself, determinative*…" Furthermore, "*A person normally has no reasonable expectation of privacy in the areas around the front of his or her home 'where members of the public having business with the occupants' would naturally go or see. Indeed, the test for any area immediately surrounding a residence is whether it is an area where the public has been implicitly invited*…" Per SDSO P&P Section 2.51, Arrest, Search and Seizure: *"Employees shall not make any arrest, search or seizure, nor conduct any investigation or official Office business, in a manner which they know or ought to know is not in accordance with law and established Office policies and procedures."* The investigation proved the alleged act did occur but was lawful, justified, and proper.

2. Excessive Force – Deputies 3, 4, 6 and 7 used force against an aggrieved on 05-13-25.

   Board Finding: Action Justified
   Staff Recommended Finding: Action Justified
   Rationale: Complainant Jonathan Diaz said, *"investigate the use of force the other officers did against our neighbor." "They claimed they had to punch him to gain compliance he was showing pre-assaultive behavior."* Attempts to contact the aggrieved were unsuccessful. SDSO reports verified by Body Worn Camera (BWC) showed on 05-13-26, the aggrieved failed to yield to deputies after they attempted to stop him for traffic violations. The aggrieved drove another 1.3 miles and stopped at his residence. He jumped out of the car and would not comply with deputy's commands. Instead, the aggrieved walked away towards his residence. Deputies ran towards him, telling him he was under arrest and to stop. The aggrieved failed to comply and he was taken to the ground. Deputies attempted to handcuff the aggrieved, who struggled and kicked at deputies. Per Deputy 6, *"(Aggrieved) continued to resist and got up and attempted to flee."* Deputies 3, 4, Deputy 6 and 7 used force including *"punching*" and *"downward pressure"* to gain control of him. The aggrieved sustained scratches, abrasions and a lump on his head. He was medically evaluated at the scene and transported to a hospital prior to booking. Per SDSO P&P Section 6.48, Physical Force: *"It shall be the policy of this Office whenever any Deputy Sheriff of this Office, while in the performance of his/her official law enforcement duties, deems it necessary to utilize any degree of physical force shall only be that which the Deputy Sheriff believes necessary and objectively reasonable to effect the arrest, prevent escape or overcome resistance (per 835(a) PC). Deputies shall utilize appropriate control techniques or tactics which employ maximum effectiveness with minimum force to effectively terminate, or afford the Deputy control of, the confrontation incident."* Per P&P 11.2, Use of Force Definitions: *Totality of Circumstances: "Means all facts known to the peace officer at the time, including the conduct of the peace officer and the subject leading up to the use of force." Takedown: "A method for taking a subject to the ground to control the subject and*

the situation. The primary objective of a takedown is to gain control of a subject and may be performed individually or by multiple deputies." Excessive Force: "A level of force that violates California state law or the United States Constitution. Excessive force is evident when the type, degree, or duration of force employed was not objectively reasonable." Per P&P 11.13, Personal Body Weapons: *"Personal body weapons may be used to strike available targets to control an actively resistant or assaultive subject. Personal body weapons may include hands, fists, arms, elbows, legs, knees, feet, and head. Some strikes may result in serious bodily injury and are generally used against a higher level of subject resistance. Some strikes may be used to facilitate a takedown or gain control of an actively resistant subject. These types of strikes are not intended, nor likely to cause serious bodily injury. Punching and kicking techniques may be necessary when a subject is assaultive. A fist strike to a subject's head is not prohibited; however, it is preferable to use an open hand (palm heel) technique to reduce the likelihood of injury to the deputy's hand and subject's face. Certain parts of the body are vulnerable to serious bodily injury or death. These include a subject's head, neck, heart, spine, kidneys, and groin. Deliberately targeting these areas must be objectively reasonable and necessary."* The investigation proved the alleged act did occur but was lawful, justified, and proper.

3. Excessive Force – Deputies 1, 2, and 5 used force on Abagail Persson on 05-13-25.

   Board Finding: Action Justified
   Staff Recommended Finding: Action Justified
   Rationale: Complainant Abagail Persson reported, *"Deputy 2 used his legs to throw me off balance and take me to the ground." "He slammed to the ground; he and another officer put all their weight on top of me."* See Rationales 1 and 2. Deputy 2 entered the picket fence on the front yard and addressed both females again telling them, *"That's an officer safety issue, you need to stop doing that." "Persson then disregarded my instructions and attempted to walk past me quickly towards deputies. I attempted to gain control of her left arm, to prevent her from approaching and interfering with deputies who were on the ground actively attempting to place Meza in handcuffs."* "*I guided Persson to the ground, and she resisted and rolled onto her back. Persson began screaming," Bro no, my baby! What the fuck? Babe!" She broke from my grasp of her right arm. I attempted to grab Persson's left hand, and she rolled away and kicked me multiple times in my torso area, dislodging my radio microphone. Deputy 1 and I rolled Persson onto her chest and I gained control of her right wrist.*" Deputy 5 arrived and assisted by placing *"downward pressure"* on Persson's legs. Per SDSO P&P Section 2.51, Arrest, Search and Seizure: "*Employees shall not make any arrest, search or seizure, nor conduct any investigation or official Office business, in a manner which they know or ought to know is not in accordance with law and established Office policies and procedures*." The investigation proved the alleged act did occur but was lawful, justified, and proper.

4. Excessive Force – Deputy 2 used force on Jonathan Diaz on 05-13-25.

   Board Finding: Action Justified
   Staff Recommended Finding: Action Justified
   Rationale: Complaint Diaz reported*, "He did not need to throw me to my knees the way he did. He could have used a verbal command to get me to put my hands behind my back. Instead, he instantly used force to take me to the ground."* SDSO Reports, BWC and CCTV showed Diaz moving quickly out the front door. There was about eight feet between Diaz and the active struggle with Persson. Due to the screaming during the use of force of Presson, additional deputies ran over from the pursuit incident. Deputy 2 and the other deputies yelled at Diaz to *"get back"* and *"stay back!"* Deputy 2 grabbed Diaz and pulled him to the ground, where an additional deputy assisted in handcuffing him. SDSO P&P Section 11.1, Policy: *"While no policy can anticipate every conceivable situation or circumstances deputies may face, deputies are expected to exercise sound judgement and use critical decision making when using force. Deputies may only use a level of force they reasonably believe is proportional to the seriousness of the suspected offense or the reasonably perceived level of actual or threatened resistance."* SDSO P&P Section 11.2, Use of Force Definitions: Takedown; Rationale 1. The investigation proved the alleged act did occur but was lawful, justified, and proper.

5. False Arrest – Deputy 2 arrested Abigail Persson on 05-13-25.

Board Finding: Action Justified
Staff Recommended Finding: Action Justified
Rationale: Complainant Persson stated, *"I did not obstruct Deputy 2 in any way."* See Rationale 3. Deputy 2 told her to stay where she was. Persson tried to push past Deputy 2 despite the fact he had just informed Persson and her companion, *"That's an officer safety issue, you need to stop doing that."* Once a struggle ensued, Persson kicked Deputy 2 "*multiple times in my torso area, dislodging my radio microphone."* Persson was charged with Obstruct/Resist Executive Officer with minor injury. Per P&P Section 2.51, Arrest, Search and Seizure: *"Employees shall not make any arrest, search or seizure, nor conduct any investigation or official Office business, in a manner which they know or ought to know is not in accordance with law and established Office policies and procedures."* The investigation proved the alleged act did occur but was lawful, justified, and proper.

6. False Arrest – Deputy 2 arrested Jonathan Diaz on 05-13-25.

Board Finding: Action Justified
Staff Recommended Finding: Action Justified
Rationale: Complainant Diaz stated, "*I did not obstruct Deputy 2 in any way."* As noted in the above rationales, the aggrieved brought deputies onto the property occupied by Persson and Diaz. This contact turned into a use of force where Persson was screaming for her boyfriend, Diaz. Diaz exited his residence and was about eight feet from the active struggle between Persson and Deputy 2. Deputy 2 and other deputies told Diaz to *"get back, stay back."* Diaz kept moving and Deputy 2 had to turn away from Persson leaving one deputy holding her down and directing his attention now on Diaz. Per California Pena Code 148(a), *"resisting, obstructing or delaying a peace officer in the performance or attempted performance of their duties. Where a subject willfully resisted, obstructed or delayed a peace officer and the subject reasonably should have known that the peace officer was performing their duties."* Per SDSO P&P Section 2.51, Arrest, Search and Seizure: *"Employees shall not make any arrest, search or seizure, nor conduct any investigation or official Office business, in a manner which they know or ought to know is not in accordance with law and established Office policies and procedures."* The investigation proved the alleged act did occur but was lawful, justified, and proper.

AYE: 8 (Pintar, Mendleson, Woods, Brown, Dumas, Fasano, Moody, Thomas)
NAY: 0

25-130/GONSALVEZ

1. Use of Force Resulting in Great Bodily Injury – Deputies Luis Escobar and Andre Hollister used force on Joseph Gonsalves.

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 07-24-25, SDSO's Special Enforcement Detail (SED) served a search warrant at a residence in El Cajon. Joseph Gonsalves was wanted for domestic violence and assault with a deadly weapon. He was known to have access to a firearm. During the nearly six-hour standoff, Gonsalves remained barricaded inside his residence and refused to comply with multiple public announcements encouraging him to exit his residence and surrender. The announcements included, "*Exit the residence with nothing in your hands or force may be used, which could result in injury."* The Crisis Negotiation Team (CNT) was utilized to establish communication and have Gonsalves voluntarily surrender. Chemical agents were deployed three separate times into the residence. A drone was also sent inside to assist SED and Gonsalves destroyed it. Deputies entered the residence to arrest Gonsalves and located him in a second level bedroom. The bedroom door was barricaded from the inside with furniture. SED broke open the door of the bedroom and told Gonsalves multiple times to show his hands. Gonsalves did not comply and Deputy Escobar deployed a 12-guage less lethal munition round and Gonsalves replied, *"Fuck you!"* Deputy Escobar deployed a second munition round. The rounds hit Gonsalves both times, but he continued to curse the deputies and not follow their orders. Deputy Hollister sent his canine partner into the bedroom and gave him the command to bite. At this point, Gonsalves was falling to the ground from the impact of the munition rounds. It was a short distance between the threshold of the bedroom door and Gonsalves. When the canine reached Gonsalves, he was no longer standing and the canine bit Gonsalves' face. Deputy

Hollister immediately grabbed his partner and saw Gonsalves holding the dog's mouth shut. SED secured Gonsalves in handcuffs and he was escorted downstairs and outside for medical treatment by deputies and medics. An ambulance arrived and Gonsalves was transported to a hospital and subsequently booked into custody. SDSO P&P 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."* SDSO K9 Unit Manual, Section 4 "*A canine may be used to locate and apprehend a suspect if the canine handler reasonably believes that the individual has either committed, is committing, or threatening to commit any serious offense and if any of the following conditions exist: (a) There is a reasonable belief the suspect poses an imminent threat of violence or serious harm to the public, any deputy/officer, or the handler. (b) The suspect is actively resisting or threatening to resist arrest, and the use of a canine reasonably appears to be necessary to overcome such resistance. (c) The suspect is believed to be concealed in an area where entry by anyone other than the canine would pose a threat to the safety of deputies/officers or the public. 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."* SDSO P&P 11.20 Less Lethal Munitions/Projectiles, "*Less Lethal Impact Munitions are projectiles used as intermediate force options against subjects exhibiting assaultive or life-threatening behavior. They are less likely to result in serious bodily injury or death and can be a resource to de-escalate a potentially deadly situation."* SDSO P&P 11.24 Aftercare, "*Whenever a subject requires or reasonably request medical aid, and/or transport them to an emergency medical facility when safe to do so."* The investigation proved the alleged act did occur but was lawful, justified, and proper.

AYE: 8 (Pintar, Mendleson, Woods, Brown, Dumas, Fasano, Moody, Thomas)
NAY: 0

25-155/RUDDICK

1. Illegal Seach and Seizure – Deputies 1, 2 and 3 detained William Ruddick on 12-20-25.

Board Finding: **Not Sustained**
Staff Recommended Finding: Action Justified
Rationale: Complainants Shannon and William Ruddick reported Deputy 1 did not have *"probable cause*" to detain William. Other parties on scene were also asking for a *"warrant"* for deputies to be on the property. Deputies tried to explain their reasoning for being at the address but everyone was confused about why deputies were there. Prior to arriving on scene, deputies received information from Poway deputies that a van registered to the Ruddick's address was possibly occupied by a driver under the influence with a 7-year-old passenger. A reporting party expressed concern over a *"child"* being in the van with a driver who appeared to have been drinking. Santee deputies received the call from dispatch. Deputies arrived on scene and saw the *"van"* parked in front of the Ruddick's residence facing the wrong direction. Deputies attempted to talk to the owner of the van and were met with confusion, and William did not comply with the deputies' request to come down the driveway to talk to them, so Deputy 1 went up to William. Believing a crime had just occurred, Deputy 1 told William he was *"detained and not free to leave."* William asked, *"What's your probable cause?*" Deputy 1 and William were now standing in front of the garage in the driveway. The Arrest Report stated Deputy 1 went to the front door (of the residence), but BWC showed he only approached the garage door when he contacted William. William was standing in front of a large package on a pallet, holding a pair of needle nose pliers. Deputy 1 told William to put the pliers down. William told Deputy 1 it was not a knife and kept the pliers in his hand. William then stepped toward the inside of the garage. Deputy 1 grabbed William's arm, he resisted and force was used. Terry v Ohio, 392 U.S. 1 (1968): *"…reasonable suspicion is a legal standard that allows a police officer to briefly detain a person… the officer must reasonably suspect that a crime has happened, is happening, or is about to happen.*" Reasonable suspicion is a lower standard than Probable Cause, "*A detention may occur either through the use of force or a show of authority. A detention through a show of authority occurs when an "officer's words and actions would have conveyed to a reasonable person that he was being ordered to restrict his movement."* Where deputies approached Ruddick*, "The portion of an open, unfenced driveway that connects directly to the street and serves as the primary walkway to the front door is generally not considered protected curtilage. Because it is open to public access, the law recognizes an "implied license" allowing the public—and the police—to step onto it for legitimate purposes, like a "knock and talk,"* Collins v. Virginia, 584 U.S._ (2018). Per SDSO P&P 2.51, Arrest, Search and Seizure, "*Employees shall not make any arrest, search or seizure, nor conduct any investigation*

or official Office business, in a manner which they know or ought to know is not in accordance with law and established Office policies and procedures." ~~The investigation showed the alleged act did occur but was lawful, justified, and proper.~~ **The investigation failed to prove or disprove the allegation by a preponderance of evidence.**

AYE: 8 (Pintar, Mendleson, Woods, Brown, Dumas, Fasano, Moody, Thomas)
NAY: 0

2. Excessive Force – Deputies 1, 2 and 3 used force on William Ruddick on 12-20-25.

   Board Finding: Action Justified
   Staff Recommended Finding: Action Justified
   Rationale: Complainants William and Shannon Ruddick reported, *"We were all very confused." "One of the officers* (deputy) *spoke in a stern loud voice asking about a white van and a 7-year-old child." They spoke to us in an accusatory manner……we were all very confused." "We had not driven the van in about an hour…" "The officer* (deputy) *continued to demand where the 7-year-old child is." "I kept saying we don't have a 7-year-old."* William was *"tazed and punched in the head and chest (during the struggle with deputies)." "The male* (deputy) *never stopped punching him even though he was on his belly detained face down for about 5 minutes." "There was also a knee on my husband's neck for some time at some point."* See Rationale 1. When Deputy 1 grabbed William's arm and a struggle ensued, Shannon came from behind and shoved 3, causing her to fall to the ground. This shove was captured on BWC. Deputy 1 delivered *"a series of closed fist strikes to* (William's) *face."* During those strikes, William was partially on top of Deputy 1. BWC did not show William on his back when Deputy 1 was punching him. 3 went to the aid of Deputy 1 and saw William *"hitting Deputy 1."* 3 used her *"left knee and struck William 3 times on the right side."* 2 then used his Taser on William, but William continued to resist. Deputies 1 and 3 continued to detain William until additional deputies arrived. Two more deputies assisted and used *"downward pressure*" to gain control of William. BWC did not show any deputy holding their knee on William's neck. While deputies were holding William face down trying to handcuff him, they did have their knees on his upper back prior to William being secured in handcuffs. The struggle with William lasted over four minutes. Deputies summoned paramedics for injuries William and 3 sustained and both received care at a medical facility. William and Shannon were both arrested and transported to detention facilities for booking. Section 11.2, Totality of Circumstance: *"Means all facts known to the peace officer at the time, including the conduct of the peace officer and the subject leading up to the use of force."* Section 11.13, Personal Body Weapons: *"Personal body weapons may be used to strike available targets to control an actively resistant or assaultive subject. Personal body weapons may include hands, fists, arms, elbows, legs, knees, feet, and head. Some strikes may result in serious bodily injury and are generally used against a higher level of subject resistance. Some strikes may be used to facilitate a takedown or gain control of an actively resistant subject. These types of strikes are not intended, nor likely to cause serious bodily injury. Punching and kicking techniques may be necessary when a subject is assaultive. A fist strike to a subject's head is not prohibited; however, it is preferable to use an open hand (palm heel) technique to reduce the likelihood of injury to the deputy's hand and subject's face. Certain parts of the body are vulnerable to serious bodily injury or death. These include a subject's head, neck, heart, spine, kidneys, and groin. Deliberately targeting these areas must be objectively reasonable and necessary."* The investigation proved the alleged act did occur but was lawful, justified, and proper.

3. Excessive Force – Deputy 1 *"pushed*" the aggrieved (juvenile) to the ground.

   Board Finding: Unfounded
   Staff Recommendation: Unfounded
   Rationale: Complainant Shannon Ruddick reported that she was told a child on scene was *"pushed to the ground"* by deputies and sustained a bruise. The juvenile's father and adult brother who were present during the incident were interviewed. The father did not witness the initial struggle but knew his son was caught up in it. He stated that his son did not have any physical injuries from the incident. The adult brother saw his little brother caught between the deputy and William Ruddick. The adult brother was uncertain whether the child freed himself or if he was pushed out of the struggle. The adult brother saw the juvenile stumble as he became free from the deputy and William but never saw him fall to the ground. The adult brother did not see any injuries to the child. The investigation proved the allegation is not true by a preponderance of evidence.

4. Misconduct/Procedure – Deputies 1, 2 and 3 failed to de-escalate.

Board Finding: Not Sustained
Staff Recommendation: Not Sustained
Rationale: Complainant Shannon Ruddick reported, *"We also asked if anyone was trained in de-escalation because the officer came in aggressively looking for a conflict."* At the time of the contact, Deputy 1 believed he had reasonable suspicion to detain William. Deputy 1 later identified that some of his information was incorrect. ~~At the time, his actions were within the *"Good Faith"* doctrine. Deputy 1's actions were not arbitrary. In his mind, he believed he had reasonable suspicion to detain Ruddick for a DUI investigation and to check the welfare of a child. Brinegar v United States reads, *"Because many situations which confront officers in the course of executing their duties are more or less ambiguous, room must be allowed for some mistakes on their part. But the mistakes must be those of reasonable men, acting on facts leading sensibly to their conclusions of probability."*~~ P&P Section 11.7 reads in part, *"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…Force options- reasonable use of force techniques may reduce the situational intensity for the safety of all parties."* Deputy 1 used an armbar take down technique to try to move William away from others present for his safety. When William resisted, additional force was used to gain control of William. SDSO 11.7 additionally reads… *"De-escalation does not require a deputy risk their safety or the safety of the public."* The investigation failed to prove or disprove the allegation by a preponderance of evidence.

5. Misconduct/Discourtesy – Unidentified deputies "*laughed*" while on scene.

   Board Finding: Not Sustained
   Staff Recommendation: Not Sustained
   Rationale: Complainant Shannon Ruddick reported that *"While we were giving our statements the police officers involved from the beginning were looking at the female's phone and laughing. We were all surprised that a professional would act the way they did after this situation."* Laughing was not witnessed or heard during BWC review of the deputies on scene. The investigation failed to prove or disprove the allegation by a preponderance of evidence.

6. Misconduct/Procedure – Deputies 1, 2 and 3 failed to check the welfare of a minor.

   Board Finding: Unfounded
   Staff Recommendation: Unfounded
   Rationale: Complainant Shannon Ruddick reported that there was never any *"welfare check"* done on any child. Deputies told the Ruddick's they needed to check the welfare of a 7-year-old child. After the deputy's initial contact with William, the incident turned into a use of force. Subsequently, per BWC, deputies did account for the children who lived at the residence. Their information was obtained and a Child Protective Service order was completed by deputies. The investigation proved the allegation is not true by a preponderance of evidence.

ALLEGATIONS 2, 3. 4. 5. 6
AYE: 6 (Pintar, Mendleson, Woods, Brown, Moody, Thomas)
NAY: 2 (Dumas, Fasano)

26-004/CROCKETT

1. False Arrest – Deputy 1 arrested Crockett Sr. on 11-19-25.

   Board Finding: Action Justified
   Staff Recommended Finding: Action Justified
   Rationale: Complainant Cleveland Crockett Sr. reported "*On* [11-19-25] *this same officer and another female officer showed up at my home put handcuff on me. Neither one of them advise me or [sic] my rights or show me a Warrant. Just put your hand behind you. This was done in front of my neighbors and my wife*." The evidence showed SDSO deputies arrived at Crockett's residence to serve Court paperwork. Additionally, Crocket was noted to have an active arrest warrant. The evidence confirmed Crockett had two active arrest warrants. Crockett was arrested and transported to Vista Detention Facility (VDF). SDSO P&P Section 2.51,

Arrest, Search and Seizure, stated, "*Employees shall not make any arrest, search or seizure, nor conduct any investigation or official Office business, in a manner which they know or ought to know is not in accordance with law and established Office policies and procedures.*" The investigation proved the alleged act did occur but was lawful, justified, and proper.

2. Misconduct/Procedure – Deputy 1 did not respond to Crockett Sr.'s request.

   Board Finding: Unfounded
   Staff Recommended Finding: Unfounded
   Rationale: Per Crockett's complaint, "*I kept asking this officer to release the handcuff because they was so tight my hand turn RED.*" The evidence showed that while Deputy 1 was completing paperwork related to Crockett's arrest, Crockett made a request for his handcuffs to be adjusted. Crockett stated, "*my circulation is being cut off ma'am...*" Within 1 minute, Deputy 1 adjusted the handcuffs placed on Crockett. SDSO P&P Section 2.48, Treatment of Persons in Custody, stated, "*Employees shall not mistreat, nor abuse physically or verbally, persons who are in their custody. Employees shall handle such persons in accordance with law and established Office procedures.*" The investigation proved the allegation is not true by a preponderance of evidence.

3. Illegal Search & Seizure – Deputy 1 actions made Crockett Sr. feel "*unsafe.*

   Board Finding: Action Justified
   Staff Recommended Finding: Action Justified
   Rationale: Per Crockett's complaint, "*On* [12-30-25]… [when] *I return home there was this officer with another female officer with her, I pulled into my garage and tried to close the door and this officer put her foot under the door to stop it. She stated she had paper to served* [sic] *me. I went to my front and refuse to open the door because my last encounter with this officer was a bad experience for me and my family… the conduct of this officer on* [12-30-25] *make it feel unsafe to live here.*" The evidence showed, on 12-30-25, Deputy 1 and a Community Services Officer (CSO) arrived at Crockett's residence to provide Court paperwork. As Deputy 1 parked near the front of Crockett's residence, Crockett was observed standing near the back of a parked vehicle in the garage of his residence. Deputy 1 walked towards the garage door and stated, "*Mr. Crockett… you got Court paperwork.*" As Deputy 1 was walking to the garage, the door of the garage began to close. Deputy 1 stopped the garage from closing by triggering the sensor of the garage door. The garage door did not open. Deputy 1 did not enter the garage or the residence. Deputy 1 stated, "I *got Court paperwork for you… come to the door… open your garage…*" Crockett refused to open the garage door. Deputy 1 stated to Crockett, "*you're not in trouble. I have this to hand over to you. I have paperwork to hand over to you.*" Crockett went to the front door of his residence and communicated with the deputies through the door but did not open the door of residence. Deputy 1 advised Crockett the details of a Court ordered restraining. Crockett stated, "*…okay hang it on my door…"* After Deputy 1 finished advising Crockett of the restraining order details, the order was left at the front door of Crockett's residence. Deputy 1 and the CSO left Crockett's residence. SDSO P&P Section 2.22, Courtesy, stated, "*Employees shall be courteous to the public and fellow employees. They shall be tactful in the performance of their duties, shall control their tempers, exercise patience and discretion even in the face of extreme provocation. Coarse, profane, or violent language is generally prohibited. Employees shall not use insolent language or gestures in the performance of his or her duties*." SDSO P&P Section 2.51, Arrest, Search and Seizure, stated, "Employees shall not make any arrest, search or seizure, nor conduct any investigation or official Office business, in a manner which they know or ought to know is not in accordance with law and established Office policies and procedures." The investigation proved the alleged act did occur but was lawful, justified, and proper.

AYE: 8* (*Pintar, Mendleson, Woods, Brown, Dumas, Fasano, Moody, Thomas)
NAY: 0

26-005/MILLER

1. False Reporting – Deputy 1 included *false* information in a report.

   Board Finding: Unfounded
   Staff Recommended Finding: Unfounded
   Rationale: Per Stephen Miller's complaint, "*The deputy's report falsely states that an employee removed me*

from the bar, misrepresents the reason for my call, and omits that a person provoked me and snatched my phone while my arm was in a sling. Video evidence was available but not reviewed, and the call was classified as 'unfounded,' misrepresenting the facts." The evidence showed, on 03-30-25, SDSO Deputies were dispatched to a restaurant in Vista, CA. The dispatch notes stated, "*Emp kicked RP out and tried to grab RP's bottle of liquor...1142… RP is HBD… No 115… No Weaps… Corr: Patron of restaurant 242'd RP and grabbed his liquor bottle… NFD*". Deputies spoke with the involved parties of the incident, and no arrests were made or citations issued. No deputy reports were completed related to the incident, other than notes left in the Computer Aided Dispatch (CAD) log. SDSO P&P Section 2.30 Failure to Meet Standards, stated, "*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 proved the allegation is not true by a preponderance of evidence.

2. Misconduct/Procedure – Deputy 1 failed to take appropriate action.

   Board Finding: Unfounded
   Staff Recommended Finding: Unfounded
   Rationale: Per Miller's complaint, "*The deputy's report falsely states that an employee removed me from the bar, misrepresents the reason for my call, and omits that a person provoked me and snatched my phone while my arm was in a sling. Video evidence was available but not reviewed, and the call was classified as 'unfounded,' misrepresenting the facts.*" See Rationale 1. Deputies spoke with witnesses to the incident. Miller was described to be standing outside of the restaurant making gestures towards patrons of the restaurant while "*taking shots of whiskey*." Deputies spoke to Miller to obtain a statement. When asked, "*what's going on...*" Miller stated, "*Oh well, I kind of just want to protest because they fucked me about a month ago. So I was there. I paid my bill, just enjoying my time. I told the bartender. She asked me, do you want one more beer? I said yes, I paid my bill. I asked to pay my bill so I can finish my stuff. One month ago. You guys can figure out what I'm talking about. But what happened was somebody at the table behind me screamed at me out of nowhere, told me to leave here. And then the bartender, because they told me that what if she told me to leave and then she lied to dispatch. She said I was fighting everybody. OK, Nobody touched anybody."* The statement Miller provided was regarding an incident that occurred on 02-26-25 and was previously investigated by CLERB in case 25-111. Regarding this incident, Miller stated, "*I would like to press charges on that guy, if possible."* Deputy 1 asked*, "for what?*" Miller responded, "*He came out here and he tried to take my stuff. And then he grabbed my phone from me.*" Deputies noted Miller had a bottle of alcohol and stated to Miller, "*You do understand you cannot have that bottle liquor out here, right?*" Miller responded, "*I understand, sir.*" Miller stated he would go home if the deputies allowed him to. Miller stated, "*I got my point across. I feel a little bit better. I can exist.*" Miller stated, "*Squash it. Squared away.*" Miller left the area without incident. SDSO P&P, Section 2.30 Failure to Meet Standards, "*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 proved the allegation is not true by a preponderance of evidence.

AYE: 8 (Pintar, Mendleson, Woods, Brown, Dumas, Fasano, Moody, Thomas)
NAY: 0

26-010/CUNNINGHAM

1. Illegal Search & Seizure - Deputies 1 and 2 detained Cunningham at George Bailey Detention Facility (GBDF) on 01-25-26.

   Board Finding: Action Justified
   Staff Recommended Finding: Action Justified
   Rationale: Leonard Cunningham reported, "…*After the visit, I ask badge # from two Deputy. Shortly after that I was detain & harass. Deputy 2 had stop me and said my ID was expire. That was false…I was detained for asking their badge #."* Deputies 1 and 2 were assigned as Visitor and Perimeter Enforcement Deputies (VPED). Per SDSO 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…"* At the driveway entrance to GBDF is posted signage, "*All persons, property, and vehicles are subject to search."* Deputies responded to the lobby of GBDF after an unidentified SDSO clerk reported Cunningham was upset. Deputies contacted Cunningham who described having phone issues during his scheduled visit with an incarcerated person. Deputies worked to resolve the issue with the phones and Cunningham returned to the visiting area. Deputies left the lobby. After Cunningham's visit was over, Cunningham went into the parking lot and initiated contact with Deputy 1. Deputy 1 provided their name and identification number. Deputy 2 arrived and spoke with Cunningham. Deputy 2 provided their name and identification number. During Cunningham's initial check-in, Deputy 2 recognized Cunningham's driver's license was expired. Cunningham drove to GBDF. Deputy 2 conducted another DMV records inquiry of Cunningham's driver's license. The information returned indicated that Cunningham's driver's license was expired. Per California Vehicle Code 12500(a), *"A person may not drive a motor vehicle upon a highway, unless the person then holds a valid driver's license issued under this code, except those persons who are expressly exempted under this code."* Cunningham agreed to obtain DMV paperwork from his vehicle that indicated his license was current. Deputies met Cunningham at his vehicle. Cunninham provided a valid temporary driver's license document from the California DMV with an expiration date of 02-06-26. 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… Screening will include an identification check for approved Sheriff's Office identification."* Cunningham initiated contact with Deputy 1 in the parking lot. The investigation proved the alleged act did occur but was lawful, justified, and proper.

2. Misconduct/Harassment – Deputies 1 and 2 "harassed*"* Cunningham on 01-25-26.

   Board Finding: Not Sustained
   Staff Recommended Finding: Not Sustained
   Rationale: Cunningham reported*, "After the visit, I ask badge # from two Deputy. Shortly after that I was detain & harass. Deputy 2 had stop me and said my ID was expire. That was false..."* See Rationale 1. Cunningham approached Deputy 1 in the parking lot to obtain deputies' names and identification numbers. Cunningham was informed that the driver's license he provided at check-in was expired. Cunningham drove to GBDF. Cunningham advised he had paperwork in his vehicle that documented his license was not expired. Cunningham provided a valid document from CA DMV indicating he had a temporary driver's license that expired at a future date. Per 12500(a) CVC: *A person may not drive a motor vehicle upon a highway unless the person then holds a valid driver's license issued under this code…* 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… Screening will include an identification check for approved Sheriff's Office identification."* The investigation failed to prove or disprove the allegation by a preponderance of evidence.

3. Misconduct/Procedure - Deputy 1 failed to activate their Body Worn Camera (BWC) on 01-25-26.

   Board Finding: Unfounded
   Staff Recommended Finding: Unfounded

Rationale: Cunninham reported, *"Deputy 1 didn't have his body cam on."* See Rationales 1 and 2. CLERB reviewed BWC from Deputy 1 that included both the lobby and the parking lot. The investigation proved the allegation is not true by a preponderance of evidence.

AYE: 8 (Pintar, Mendleson, Woods, Brown, Dumas, Fasano, Moody, Thomas)
NAY: 0

26-011/DOE 2601

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

26-016/BROOKS

1. Use of Force Resulting in Great Bodily Injury – Deputies Malcolm Chennault and Joaquin Munoz used force against Corey Brooks on 01-25-26.

   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. Records related to this incident showed Incarcerated Person (IP) Corey Brooks was arrested by San Diego Police on 01-24-26 and booked into San Diego Central Jail (SDCJ) with a court date scheduled for 01-28-26. On 01-25-25, a deputy overheard several unidentified IP's complaining that Brooks was causing problems in his housing module. The housing deputy decided to move Brooks out of the module for his safety. The deputy consulted the Jail Population Management Unit (JPMU) who recommended Brooks be moved from the 8th floor to the 6th floor. IP Brooks became agitated during his removal, was secured in handcuffs and placed into a holding cell while alternate housing was sought. Per Body Worn Camera (BWC) footage, at about 11:55pm, Deputy Munoz and an unidentified deputy removed Brooks from the holding cell and escorted him to an elevator. Brooks was agitated, however indicated a willingness to comply and was not secured in handcuffs. Brooks entered the elevator with Deputy Munoz. Deputy Munoz told Brooks, "*Look at that wall right there behind you sir, don't look at me*." Brooks did not respond to Deputy Munoz's command and stood facing him with his arms crossed. Deputy Munoz allowed Brooks to remain as he was during the elevator ride. Per BWC, Brooks exited the elevator and when he learned he was being placed into a different module, became extremely agitated and repeatedly demanded his release. Deputy Chennault and a Lieutenant walked toward Brooks while the Lieutenant verbally engaged Brooks saying, "*Check this out, I can help you out with that release but for now you need to listen to those guys, were gonna put you somewhere and I'll look up your release*." Brooks remained agitated, continuing to demand his release. The Lieutenant continued to try and de-escalate Brooks stating, "*Brooks, I got you I'm giving you my word, I'm gonna go check for you alright*." As the Lieutenant was speaking, Brooks loudly interrupted stating, "*Your just trying to put me in a cell right now and you found me outside for fucks sakes you fucking faggot*." While Brooks continued to yell, the Lieutenant asked him, "*What's the solution, what's the solution to this, just relax, lower your voice, what's the solution*?" After about 1:40 seconds of verbal attempts for compliance, Brooks yelled, "*I'll swing dude, I don't give a fuck*" while pulling his right arm sleeve up, appearing to prepare to fight. The Lieutenant continued to try and speak with Brooks and direct his attention onto himself. Per SDSO P&P 11.7 De-escalation, "*De-escalation is defined as the process of using strategies and techniques intended to decrease the intensity of the situation*." Brooks agitation level continued to elevate and about two minutes into their interaction, Brooks looked at the Lieutenant, brought his clenched fists in front of him and yelled, "*Now I'm gonna swing if you touch me I'm gonna fucking hit you.*" The Lieutenant told Brooks to turn around for handcuffing and Brooks refused. Per the Lieutenant's report, he made the decision to place Brooks into handcuffs based on his "*verbal threats, agitated state, assaultive behavior and failure to comply with instructions*." Per BWC, Deputies Chennault and Munoz grabbed Brooks to handcuff, and he immediately resisted yelling "*No*" while clenching his fists and trying to pull his arms toward his body to avoid handcuffing. While deputies were struggling to gain control of Brooks, the Lieutenant ordered Deputies Chennault and Munoz to "*dump him*." Per BWC, Deputy Chennault grabbed Brooks from behind, lifted him up and took him to the ground. SDSO P&P 11.9 Types of Resistance defined assaultive behavior as, "*attempting to assault the deputy or another person, or verbally or physically displaying an intention to assault the deputy or another person*." Per SDSO P&P 11.11 Use of Force Matrix, "*Take-downs*" are authorized based on assaultive behavior and active resistance. Per SDSO P&P 11.2 Definitions, Takedowns were defined as, "*A method for taking a subject to the ground to control the subject and situation. The primary objective of a takedown is to gain control of a subject and may be*

performed individually or by multiple deputies." After Brooks was taken to the ground and while deputies were beginning to handcuff him, they realized Brooks was unconscious and bleeding from his head because of the takedown. The Lieutenant immediately requested medical personnel and activation of 911. Brooks was treated by jail medical staff, transported to a hospital via paramedics and released back to SDSO custody after treatment. The investigation proved the alleged act did occur but was lawful, justified, and proper.

AYE: 8 (Pintar, Mendleson, Woods, Brown, Dumas, Fasano, Moody, Thomas)
NAY: 0

26-018/SWAROVSKI

1. Use of Force Resulting in Great Bodily Injury – Deputy Luis Lopez Chaparro deployed his canine partner (Max) resulting in injury to Yuri Swarovski on 01-27-26

   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 01-27-26 deputies responded in response to a neighbor who reported Yuri Swarovski was, "*acting crazy and throwing rocks into the middle of the street.*" The reporting party described the rocks as "*kinda big rocks*" and was worried Swarovski would throw one at a person. When deputies arrived, Swarovski was observed naked, in the garage, throwing items out of a broken window and yelling incoherently. Deputies learned Swarovski was trespassing and subject to a Restraining Order that prohibited him from coming within 100 yards of the residence and his parents. While waiting for a supervisor, deputies observed Swarovski continue to throw items from inside the garage into the yard and out into the street through the broken window. Swarovski exited the garage and went into the backyard out of view. Deputies and a supervisor approached the residence using the driveway next door to contact Swarovski. As they began calling out to him, Swarovski began throwing rocks onto the driveway which struck a deputy in the leg and broke a window on a vehicle. Deputies withdrew to their patrol vehicle, set up a perimeter around the residence, and began amplified announcements requesting Swarovski to exit the property. Deputies continued unsuccessfully to try and contact Swarovski for about one hour prior to a drone locating him in the back yard, naked and bloody. Deputies determined they needed to approach and take Swarovski into custody. Deputies and a supervisor entered the backyard making announcements for Swarovski to come out. Swarovski did not respond to their commands and was sitting on the ground holding a toilet seat while thrashing on the ground. Deputies told Swarovski to put the toilet seat down five times, then a deputy fired four rounds of less lethal pepper ball at Swarovski. Swarovski backed up while holding the toilet seat into a small bathroom out of the deputy's sight. Deputy Lopez Chaparro deployed his canine who contacted Swarovski in the bathroom resulting in injury. Swarovski began thrashing around striking and fighting with the canine while loudly screaming. The canine was able to secure Swarovski's left forearm and pull him from the bathroom where deputies secured and handcuffed him. 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. (c) The suspect is believed to be concealed in an area where entry by anyone other than the canine would pose a threat to the safety of deputies/officers or the public. 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 SDSO 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."* Swarovski continued to resist after handcuffing and deputies placed him into a WRAP device. Swarovski was treated by paramedics at the scene and transported to Scripps Mercy for treatment prior to booking at the San Diego Central Jail. The investigation proved the alleged act did occur but was lawful, justified, and proper.

AYE: 8 (Pintar, Mendleson, Woods, Brown, Dumas, Fasano, Moody, Thomas)
NAY: 0

26-025/SYFU

1. Misconduct/Retaliation – Deputy 2 placed an Incarcerated Person (IP) in a Recreation Room on 01-17-26.

   Board Finding: Action Justified
   Staff Recommended Finding: Action Justified
   Rationale: Complainant Michael Syfu submitted a complaint on behalf of an IP, the aggrieved, who was incarcerated at San Diego Central Jail (SDCJ). Syfu reported during "*bed checks"* deputies asked the aggrieved for his name, who responded by telling them they knew who he was. Syfu stated he believed Deputy 2 thought the aggrieved was being a "*smart ass"* so he "*violently pulled [redacted] out of his cell almost hitting his head on the cell door".* Syfu stated the deputy escorted the aggrieved to the Recreation Room and *"left him there from approx. 11:00pm-4:00am"*. Per SDSO records, the aggrieved was housed in Module 5A and classified as a Level 5 "Greenbander". BWC footage showed on 01-17-26 at 12:50am, Deputy 2 was completing a Hard Count. Deputy 2 had the door to the cell opened. The aggrieved was seen lying on the bottom bunk with a towel hanging down from the bunk above blocking Deputy 2 from seeing his face. Deputy 2 asked the aggrieved what his last name was, and the aggrieved refused to provide it. Deputy 2 asked the aggrieved to see his wristband several times which the aggrieved initially ignored. The aggrieved eventually pointed at the metal table within the cell and said, "*it's over there. Use your eyes. It's on the cup. Cmon bro. I'm fucking bottom bunk… You know your job right."* Deputy 2 instructed the aggrieved to exit the cell three times and the aggrieved refused stating, "*No".* The aggrieved ultimately agreed to exit the cell. Deputy 2 permitted the aggrieved to gather his cane, his visibility vest, and his shoes. BWC footage confirmed the aggrieved exited the cell without force or incident. Deputy 2 escorted the aggrieved to the Module's Recreation Room and placed him inside at 12:52am. The aggrieved remained in the chair using the telephone until 2:48am, when Deputy 2 retrieved the aggrieved from the Recreation Room and escorted him back to his cell. Deputy 2 provided confidential statements during CLERB's investigation that were also taken into consideration for the recommended finding. Per DSB P&P I.43 County Procedures of Incarcerated Persons: *"All incarcerated persons at each detention facility shall be accounted for. Sworn staff will physically conduct counts 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 I.47 Incarcerated Persons Identification Wristbands and Clothing: "*An identifying wristband will be secured on the incarcerated person's left wrist (except in case of amputation, prosthesis or cast)."* Per DSB P&P R.3 Incarcerated Person Classification Code: *B. 5– Maximum. This incarcerated person must have a combination of two of the following: current assaultive charges, prior assaultive history, are deemed an institutional behavior problem or an escape risk. Incarcerated persons classified as assaultive or escape risks (Greenbander) will be classified as a minimum level 5."* The investigation proved the alleged act did occur but was lawful, justified, and proper.

2. Misconduct/Retaliation – Deputy 1 retaliated against an IP on unspecified dates.

   Board Finding: Unfounded
   Staff Recommended Finding: Unfounded
   Rationale: The complainant, Michael Syfu, reported that the aggrieved told him on an unspecified date in August of 2025, Deputy 1 broke the aggrieved's *"blind sweeping cane…and dark sunglasses"*. Syfu also reported Deputy 1 "*strobe lighted"* the aggrieved on multiple unspecified dates. Per SDSO records, there were no grievances or documented instances confirming the aggrieved's property had been damaged. Per SDSO records there were no grievances submitted by the aggrieved regarding Deputy 1 using his flashlight in an improper manner. The aggrieved did not respond to CLERB's request for clarifying information or access to his medical records related to use of a cane or dark glasses. Without specific dates and times, CLERB was unable to investigate further. Deputy 1 provided confidential statements during CLERB's investigation that were taken into consideration for the recommended finding. The investigation proved the allegation is not true by a preponderance of evidence.

3. Misconduct/Discourtesy – Deputy 2 was discourteous towards an IP in January 2026.

Board Finding: Not Sustained
Staff Recommended Finding: Not Sustained
Rationale: The complainant, Michael Syfu, reported that the aggrieved told him on an unspecified date in January 2026, "*informed deputies he had food poisoning and defecated"…."Deputy 2 ignored [aggrieved] and told [aggrieved] to fuck off."* Per SDSO records there were no grievances submitted by the aggrieved regarding the alleged matter. See Rationale 2. Without a specified date and time, CLERB was unable to investigate further. Per P&P 2.22 Courtesy: "*Employees shall be courteous to the public and fellow employees. They shall be tactful in the performance of their duties, shall control their tempers, exercise patience and discretion even in the face of extreme provocation. Coarse, profane, or violent language is generally prohibited. Employees shall not use insolent language or gestures in the performance of his or her duties."* The investigation failed to prove or disprove the allegation by a preponderance of evidence.

4. Misconduct/Procedure – Unidentified deputies did not respond to an IPs intercom request on 09-01-25.

Board Finding: Not Sustained
Staff Recommended Finding: Not Sustained
Rationale: The complainant, Michael Syfu, reported the aggrieved was bitten by a spider and their *"cellmates pressed the emergency button in his cell to inform the deputies, the deputies never responded"*. SDCJ does not keep a log of intercom activations throughout the facility. CLERB was unable to confirm if the intercom was activated on 09-01-25. Without specified dates, times, and a signed medical release waiver, CLERB was unable to investigate further. Per DSB P&P I.2 Intercom Systems: 1.D *"In the event of an emergency or incident, an incarcerated person is to depress the intercom call button which activates an alarm on the receiving end (e.g., Housing Control, Central Control, etc.). The alarm will alert sworn staff to a possible emergency or incident that necessitates their attention. Sworn staff will answer all intercom calls in an expeditious manner and follow-up on the nature of the call."* The investigation failed to prove or disprove the allegation by a preponderance of evidence.

AYE: 8 (Pintar, Mendleson, Woods, Brown, Dumas, Fasano, Moody, Thomas)
NAY: 0

26-058/DALCIN

1. Excessive Force – Deputies 1, 3, and 4 used force against Incarcerated Person (IP) Michael Dalcin on 01-08-26.

Board Finding: Action Justified
Staff Recommended Finding: Action Justified
Rationale: Complainant, IP Michael Dalcin, reported on 01-08-26, he was transported from court to George Bailey Detention Facility (GBDF). IP Dalcin stated his wrist was attached to an Unidentified IP's (UIP) waist restraint. IP Dalcin alleged the UIP stopped walking and Deputy 3 "*yanks my left arm by the wrist just above the cuff…lacerating my skin around my wrists."* IP Dalcin said Deputies 1 and 3 escorted him down a hallway and "*put squeezing pressure on my arm."* IP Dalcin reported he only pulled "*away from his touch to my person"* when Deputy 3 "*jumps on me* [sic] *arm wrapping around my neck, using his entire body weight to slam me".* IP Dalcin reported his head slammed against the concrete and 7-10 deputies got on top of him and he reported he "*blacked out".* IP Dalcin was among several IPs being escorted into GBDF and was restrained with wrist and waist restraints. IP Dalcin's right wrist was attached to the UIP's left waist restraint and the UIP's left wrist was attached to IP Dalcin's right waist restraint. Deputies instructed the group of IPs to walk down the hallway along a red painted line. The UIP stopped walking to speak with an unidentified deputy off the line which caused IP Dalcin to stop walking. Deputy 3 grabbed the back of IP Dalcin's left arm and instructed him to keep walking. IP Dalcin pulled his arm away from Deputy 3 and stated, "*Don't touch me".* Deputy 3 responded by grabbing IP Dalcin's left arm and escorting him offline and pressing him against the wall. Deputies 1 and 3 escorted IP Dalcin down the hall by himself and issued verbal instructions not to pull back. The deputies reached the end of the hallway where they stopped and Deputy 3 issued verbal commands for IP Dalcin to *"relax"*. IP Dalcin responded by yelling, "*Fuck you. I didn't do anything you fucking asshole!"* Deputy 3 repeatedly told IP Dalcin to calm down. IP Dalcin said, "*Fuck you dude. Do something to me. Fucking do something."* IP Dalcin made repeated attempts to pull his right arm into his body and away from Deputy 3's grip. Deputy 3 initiated a takedown by grabbing the back of IP Dalcin's shirt and using it to pull IP Dalcin down to the ground. BWC and CCTV footage showed that IP Dalcin landed on his lower

back/butt and did not appear to lose consciousness as reported in his complaint. The deputies rolled IP Dalcin onto his stomach and Deputy 3 used open hand pressure against IP Dalcin's head to keep his head pinned against the ground. Deputy 1 applied downward pressure onto IP Dalcin's back and head. Deputy 4 had observed the takedown and assisted by crossing IP Dalcin's ankles and applying downward pressure on them. Deputy 4 documented, "*At one point, I transitioned from using both of my hands to using my left knee to apply downward pressure on Dalcin's ankles so that I could place leg restraints on him".* The deputies placed IP Dalcin in the recovery position on a medical gurney and transported him to the medical unit where he was evaluated by a nurse and doctor. Per 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 P&P 11.11 Use of Force matrix, deputies are permitted to respond to active resistance with *"personal body weapons (strikes to facilitate a takedown) and physical control techniques".* The investigation proved the alleged act did occur but was lawful, justified, and proper.

2. Misconduct/Retaliation – Deputy 2 "*targeted"* IP Dalcin by housing him in Administrative Separation on 01-08-26.

   Board Finding: Action Justified
   Staff Recommended Finding: Action Justified
   Rationale: Complainant IP Dalcin reported on 01-08-26, following a use of force, deputies "*targeted"* him by housing him in Administrative Separation (Ad-Sep) for "*two weeks*". Per SDSO records, IP Dalcin was charged with violating Inmate Rules 101, 102, 103, and 701 (see below). On 01-08-26, Deputy 2 completed a Housing Separation Order for IP Dalcin to be placed in Ad-Sep which was approved by a Sergeant pending a hearing or investigation for a rule violation or criminal act. IP Dalcin remained in Ad-Sep for 13 days when he was transferred back to mainline housing on 01-20-26. IP Dalcin submitted an appeal for his charges, the discipline imposed on him, and a violation of his due process. On 02-03-26, a lieutenant responded to IP Dalcin's appeal stating, "*I found there was substantial evidence to impose discipline and the hearing itself was conducted properly."* The violations against IP Dalcin were ultimately expunged from his jail records due to an approval notification timeline error. DSB P&P Section O.1 Rules and Regulations of Incarcerated Persons: "*Rules and regulations of incarcerated persons shall be posted conspicuously in all incarcerated person housing areas. Facility staff shall ensure every incarcerated person is aware of and understands these rules"* Subsection VI: "*101 Incarcerated person(s) shall treat members of facility staff in a civil fashion. 102 Incarcerated person(s) shall obey staff instructions. 103 Incarcerated person(s) shall not threaten, assault or attempt to intimidate any other incarcerated person(s) or any member of the jail staff. 701 Incarcerated person(s) shall not engage in any activity that impairs or interferes with the operation of the facility."* DSB P&P Section IV. Administrative Separation: "*A sworn supervisor may make the determination an incarcerated person is required to be placed in administrative separation housing while the incident report is being written and pending the disciplinary hearing."* The investigation proved the alleged act did occur but was lawful, justified, and proper.

3. Misconduct/Procedure – Unidentified deputies deprived IP Dalcin of necessities while in Administrative Separation between 01-08-26 and 01-20-26.

   Board Finding: Not Sustained
   Staff Recommended Finding: Not Sustained
   Rationale: Complainant IP Dalcin reported while he was housed in Ad-Sep he was deprived of "*hygiene, showers, functioning plumbing, without literature".* IP Dalcin was housed in Ad-Sep from 01-08-26 to 01-20-26, with no documentation or grievance forms reported by IP Dalcin indicating he did not receive hygiene products, was denied showers, or that his plumbing was not functioning properly. IP Dalcin would not have been provided with reading materials in accordance with SDSO DSB Section O.1 Disciplinary Action: Subsection III. D: *"Placement into a disciplinary separation cell. This means loss of all personal items except bedding, clothing, legal papers, and personal correspondence (unless the incarcerated person has violated correspondence regulations, in which case correspondence may be suspended for no longer than 72 hours without a review and approval by the watch commander or designee) and hygiene items, unless such items are being destroyed by the incarcerated person. A Bible, Koran or other sacred material, legal items and mail shall be the only allowed reading material (no other books or periodicals)."* Title 15 Guidelines §1266

Showering: "*There shall be written policies and procedures developed by the facility administrator for showering/bathing. Incarcerated persons shall be permitted to shower/bathe upon assignment to a housing unit and at least every other day or more often if possible. Absent exigent circumstances, no person shall be prohibited from showering at least every other day following assignment to a housing unit. If showering is prohibited, it must be approved by the facility manager or designee, and the reason(s) for prohibition shall be documented."* DSB P&P L.11 Personal Hygiene: "*Any incarcerated person to be held longer than 24 hours shall be supplied with items necessary for adequate personal hygiene. Incarcerated persons may purchase hygiene items from Sheriff's Commissary. Indigent persons will be issued a welfare pack. An indigent person is defined as any person who has less than $2.00 on their account and has not had $2.00 during the previous week."* The investigation failed to prove or disprove the allegation by a preponderance of evidence.

4. Misconduct/Procedure – Unidentified deputies failed to document shower activity for IP Dalcin while in Administrative Separation from 01-08-26 to 01-20-26.

   Board Finding: Not Sustained
   Staff Recommended Finding: Not Sustained
   Rationale: Complainant IP Dalcin reported while he was housed in Ad-Sep he was not given the opportunity to take a shower. IP Dalcin was housed in Ad-Sep from 01-08-26 to 01-20-26. On 01-12-26, IP Dalcin was provided with shower access at 10:10pm. There was no additional documentation indicating if IP Dalcin was given access to a shower or if he refused a shower during the remainder of his time in Ad-Sep. GBDF has multiple deputies assigned to each module per shift. Although IP Dalcin's JIMS entry was not updated as required, CLERB was unable to identify with certainty which deputy had the responsibility of updating the IP Shower Log. Per DSB P&P L.11 Personal Hygiene: "*Once housed, an incarcerated person will be allowed a shower. At a minimum, additional showers will be offered at least every 48 hours thereafter. If showering is prohibited, it must be approved by the Facility Commander or designee. The cause for prohibition shall be documented in the Watch Commanders Log".* III. Disciplinary Separation A. "*Any incarcerated person in disciplinary separation shall be allowed a shower at least every 48 hours. A JIMS entry will be made in the incarcerated person's history using the "SHWR" drop-down to indicate when the incarcerated person was given access to the shower. If the incarcerated person chooses not to utilize the shower, an entry will be made in the incarcerated person's history using the "SHWR" drop-down and enter "REFUSED SHOWER" in the "Destination" area."* The investigation failed to prove or disprove the allegation by a preponderance of evidence.

5. Misconduct/Procedure – Unidentified jail staff failed to provide IP Dalcin a medically prescribed diet while in Administrative Separation from 01-08-26 to 01-20-26.

   Board Finding: Not Sustained
   Staff Recommended Finding: Not Sustained
   Rationale: Complainant IP Dalcin reported while housed in Ad-Sep, his diet restrictions were not followed during meal distribution. A medically prescribed diet was ordered for IP Dalcin on 09-30-25 and the order was in effect during the time he was housed in Ad-Sep. On 01-14-26, medical staff documented IP Dalcin alleged his diet restrictions were not being met. Medical staff documented they would notify the kitchen supervisor. There were no additional documented complaints made that IP Dalcin was not getting his prescribed diet. CLERB does not have the ability to verify the contents on IP Dalcin's meal trays during his stay in Ad-Sep to ensure they complied with his dietary restrictions. Per DSB P&P K.7 Medically Prescribed Diets: "*Medically prescribed diets for incarcerated persons will be provided as prescribed by a physician's written orders. VI. Sworn personnel will verify each medically prescribed diet is present on the meal delivery cart before leaving the kitchen. In facilities that do not have sworn personnel in the kitchen the verification rests on the housing deputy."* The investigation failed to prove or disprove the allegation by a preponderance of evidence.

6. Misconduct/Medical – Unidentified medical staff delayed IP Dalcin's access to medical care.

   Board Finding: Summary Dismissal
   Staff Recommended Finding: Summary Dismissal

Rationale: Complainant IP Dalcin reported, "*I wasn't seen for an x-ray until 47 days after the beating, despite an x-ray ordered on 01/09/26, and subsequently ordered by a judge on 01/28/26."* IP Dalcin was evaluated by medical staff immediately following the use of force on 01-08-26. On 01-09-26, IP Dalcin was seen by medical staff for a post use of force evaluation. IP Dalcin received a functional assessment exam and was provided with support devices and an x-ray was ordered and done on 02-24-26. IP Dalcin was seen by medical staff several times between 01-09-26 and 02-24-26. Per MSB P&P A.1.1 Access to Care: "*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 judgement, and receives care that is ordered."* Medical staff are non-sworn personnel. Per CLERB R&R 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: 8 (Pintar, Mendleson, Woods, Brown, Dumas, Fasano, Moody, Thomas)
NAY: 0

26-065/PEREZ, Andres

1. Use of Force Resulting in Great Bodily Injury - Deputies Garrett Gagliardi, Robert Healey and Evan McCormick used force on Andres Perez on 05-25-26.

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 05-25-26, deputies received two separate radio calls of an armed subject, later identified as Andres Perez. The reporting party (R/P) saw a handgun in Perez's waistband. She reported that Perez told her, "*He* (Perez*) was going to do something to "the unknown male" that took his money."* Upon deputies locating Perez, a high-risk pedestrian stop was conducted. Deputy Healey gave Perez multiple commands in English and Spanish to *"Stop right there, stop reaching, stop reaching, let me see your hands, get your hands up, get your hands up, get your hands up!"* and *"Manos arriba, manos arriba, no se mueva... veulta, veulta!"* Perez sat down but did not get on the ground. Deputies gave commands to Perez to get on the ground. Perez did not comply. Deputies then approached and pushed him to the ground and applied handcuffs. At the time of the event, no injuries were noticed by deputies and Perez did not complain of any pain or injuries, nor did he ask to be medically treated. When Perez arrived at Vista Detention Facility, a nurse *"medically rejected"* Perez for swelling to his elbow. Perez was transported to the hospital and treated for ulnar and nasal fractures. SDSO P&P 11.1, Use of Force Guidelines: *"It shall be the policy of this Office that any deputy sheriff, in the performance of their official law enforcement duties, will use force in a manner that is fair and unbiased to meet law enforcement objectives including: To effect a lawful arrest, detention, or search. To overcome resistance or to prevent escape. To prevent the commission of a public offense. In defense of others or in self-defense. To gain compliance with a lawful order. To prevent harm to the deputy or another person during intervention in a suicide or other attempt to self-inflict injury."* P&P Section 11.2, Proportional: ***"****force does not require deputies to use the same type or amount of force as the subject or the least amount of force that might be effective. The more immediate the threat and the more likely the threat will result in death or serious bodily injury, the greater the level of force that may be proportional, objectively reasonable, and necessary to counter it. Regardless of the type of force used by a deputy, the force used should always be proportional to the threat perceived by the deputy."* P&P Section 11.13, Personal Body Weapons: *"Personal body weapons may be used to strike available targets to control an actively resistant or assaultive subject. Personal body weapons may include hands, fists, arms, elbows, legs, knees, feet, and head. Some strikes may result in serious bodily injury and are generally used against a higher level of subject resistance. Some strikes may be used to facilitate a takedown or gain control of an actively resistant subject. These types of strikes are not intended, nor likely to cause serious bodily injury. Punching and kicking techniques may be necessary when a subject is assaultive. A fist strike to a subject's head is not prohibited; however, it is preferable to use an open hand (palm heel) technique to reduce the likelihood of injury to the deputy's hand and subject's face.* The investigation proved the alleged act did occur but was lawful, justified, and proper.

AYE:8 (Pintar, Mendleson, Woods, Brown, Dumas, Fasano, Moody, Thomas)
NAY: 0

26-066/PEREZ, Alan

1. Use of Force Resulting in Great Bodily Injury – Deputies Luis Solar, Carlos Zavalza Garza, Ulysses Hueso, Miguel Paramo Loaiza, Ivan Castillo, Juan Celedon and Cameron Nicks used force on IP Alan Perez on 05-30-26.

   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 05-30-26, at the George Bailey Detention Facility (GBDF), Incarcerated Person (IP) Alan Perez took a deputy's facility keyset from the cell door flap keyhole while the deputy and nurse delivered IP Perez's medications via his cell door flap. IP Perez refused to relinquish the keyset, despite numerous deputies' verbal attempts with him. A Qualified Mental Health Provider (QMHP) was brought in to speak to IP Perez but was unsuccessful in getting the IP to relinquish the keyset. IP Perez was issued further verbal warnings by the deputies who informed him force would be used on him if he did not comply and relinquish the keyset. Prior to the extraction, less lethal munitions were utilized in an attempt to gain IP Perez's compliance. IP Perez remained non-compliant and did not turn over the keyset. SDSO assembled a Tactical Response Team and made entry into IP Perez's cell to extract him and recover the keyset. During the extraction, IP Perez was non-compliant, struggled with deputies, and deputies used closed fist strikes to his body to gain compliance and handcuff him. As a result of the use of force, IP Perez suffered a fractured thumb. Per DSP I.83 Extraction, *"Cell extractions are planned tactical operations, performed under the direct supervision of the watch commander or designee, using approved techniques and equipment. The use of physical force to extract an incarcerated person(s) from a cell or other area of the detention facility will only be used when the incarcerated person(s) refuses to follow lawful orders, presents a danger to themselves, a danger to others, or causes property damage. When time safely permits, a PERT trained deputy or qualified mental health provider may be summoned for intervention. Involved incarcerated persons must be given at least two verbal warnings to comply with orders prior to extraction."* 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 Use of Force Guidelines, Sections 11.9 and 11.11, "*If a subject is actively resisting, deputies' use of personal body weapons is permitted."* Per SDSO P&P Section 11.13 Personal Body Weapons, *"Personal body weapons may be used to strike available targets reduce the likelihood of injury to the deputy's hand and subject's face. Certain parts of the body are vulnerable to serious bodily injury or death. These include a subject's head, neck, heart, spine, kidneys, and groin. Deliberately targeting these areas must be objectively reasonable and necessary."* The investigation proved the alleged act did occur but was lawful, justified, and proper.

AYE: 8 (Pintar, Mendleson, Woods, Brown, Dumas, Fasano, Moody, Thomas)
NAY: 0

Consent Agenda for Cases Recommended for Summary Dismissal pursuant to CLERB Rules and Regulations, Section 10.e.2: Summary Dismissal: (**3**)

After review by the Board, all items recommended for Summary Dismissal in Section 10.3.e are routine and may be acted upon with one (1) motion, made by the Executive Officer or a CLERB Member. There shall be no separate discussion of the items recommended for Summary Dismissal unless a CLERB Member so requests, in which event, the item(s) will be considered separately in the normal sequence in the closed session agenda.

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.

26-109/MINEO

1. Misconduct/Procedure – The San Diego Police Department (SDPD) failed to respond to a call for service on 09-05-26.

   Board Finding: Summary Dismissal
   Staff Recommended Finding: Summary Dismissal

Rationale: Complainant Kendall Mineo reported their dog was hit by a car that fled the scene in the City of San Diego. They called to report the hit and run but did not receive a response from SDPD. Pursuant to CLERB Rules and Regulations, Section 4.1, Complaints: Authority: "*CLERB shall have authority to receive, review, investigate, and report on Complaints filed against peace officers or custodial officers employed by the County in the Sheriff's Office or the Probation department*…" The Review Board lacks jurisdiction.

2. Misconduct/Harassment – The San Diego Sheriff's Office (SDSO) "*harasses*" people.

Board Finding: Summary Dismissal
Staff Recommended Finding: Summary Dismissal
Rationale: Complainant Mineo also reported, "*I've had nothing but bad luck with these law enforcement including El cajon Police department and the sheriff's department also it seems to be they forgotten what they got the job for and that's not to harass and pick and choose who they want to help I pay their paycheck I pay my taxes they have a job and a community where they don't do s*** but her ass people that don't deserve it like homeless people and people who have come upon hard times they don't want to actually go and work they rather just do the easy thing and harass people that don't deserve it and not help people that do so please look into this*…" Mineo did not respond to CLERB's request for additional information. Due to a lack of information and no identification of subject officers, CLERB is unable to conduct an investigation. The Review Board lacks jurisdiction.

26-127/ALAS

1. Misconduct/ Procedure – Deputy 1 engaged in unbecoming conduct.

Board Finding: Summary Dismissal
Staff Recommended Finding: Summary Dismissal
Rationale: Christian Alas stated in the complaint, "…*I ask CLERB to determine, to the extent within its jurisdiction, when and how [Deputy 1] first encountered [person]; whether their contacts occurred while he was on duty and responsible for an incarcerated person; when their interactions became personal; and whether personal communications or interactions occurred while he was on duty or responsible for the custody, transportation, supervision, or security of an incarcerated person….I also ask that the investigation determine whether [Deputy 1] used Sheriff's Office time, assignments, vehicles, phones, computers, databases, information, or other County resources for a personal purpose connected with the relationship; whether he intentionally sought out, prolonged, or arranged personal contact with [person] during hospital assignments; and whether any personal activity caused distraction, neglect, or inattention to official duties."* Alas reported, *"I can't identify a specific date or time when [Deputy 1] allegedly engaged in any potential misconduct."* Per Alas, he does not know when, where or how the relationship between Deputy 1 and a person began; Alas estimated it was in April 2025. Pursuant to CLERB Rules and Regulations, 4.1.2 Complaints: Jurisdiction. CLERB shall have jurisdiction in respect to all complaints arising out of incidents occurring on or after November 7, 1990. Notwithstanding the foregoing, CLERB shall not have jurisdiction to take any action in respect to complaints received more than one year after the date of the incident giving rise to the complaint…. The Review Board lacks jurisdiction.*:*

26-129/KERR

1. Excessive Force – Deputies 1, 2, and unidentified used force on 12-15-23.

Board Finding: Summary Dismissal
Staff Recommended Finding: Summary Dismissal
Rationale: Complainant David M. Kerr reported, *"On December 15, 2023, the San Diego County Sheriff's was summoned to my residence…four responding deputies escalated the situation into a severe, life-threatening deployment of force…"* Kerr verified the incident occurred on 12-15-23. Pursuant to CLERB Rules and Regulations, Section 4: 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… and 4.1.2 Complaints: Jurisdiction. CLERB shall have jurisdiction in respect to all complaints arising out of incidents occurring on or after November 7, 1990.

Notwithstanding the foregoing, CLERB shall not have jurisdiction to take any action in respect to complaints received more than one year after the date of the incident giving rise to the complaint…. The Review Board lacks jurisdiction.

All consent items
AYE: 8 (Pintar, Mendleson, Woods, Brown, Dumas, Fasano, Moody, Thomas)
NAY: 0

Adjourned 10:18 pm

End of Report