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County of San Diego

CITIZENS' LAW ENFORCEMENT REVIEW BOARD

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SPECIAL MEETING AGENDA (Amended)

Thursday, November 5, 2026, 4:00 p.m.

County Administration Center

1600 Pacific Highway, Chamber Room 327, San Diego, 92101

(Free parking is available in the underground parking garage, on the south side of Ash Street, in the public parking spaces.)

-AND-

Zoom Platform

<https://sdcounty-ca-gov.zoom.us/j/84842802910?pwd=WTm3hp8YLqLyRmaZTaZeAJkYPmUy8B.1>

Phone: +1 669 444 9171

Webinar ID: 848 4280 2910

Passcode: 375883

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

DISABLED ACCESS TO MEETING

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

WRITINGS DISTRIBUTED TO THE BOARD

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

1) ROLL CALL (1 minute)

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

3) PUBLIC COMMENTS (10 minutes)

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

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

a) CONFERENCE WITH LEGAL COUNSEL

Existing Litigation: pursuant to Government Code Section 54956.9

(a) Juvenile Probation cases

b) PUBLIC EMPLOYEE DISCIPLINE/DISMISSAL/RELEASE

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

CASES FOR SUMMARY HEARING (5)

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: Pending (Adopted/Deferred)

Conclusion: This case was reviewed in accordance with CLERB Rules & Regulations 4.3, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. On 04-20-26, Curren's father also submitted a complaint regarding the medical intake process. See Allegation 6. Evidence showed, Curren was arrested by San Diego Police (SDPD) on 08-29-25 at approximately 8:15am for charges related to a stolen vehicle. Curren was booked into San Diego Central Jail (SDCJ) where he was classified as a Level 2 IP. Curren was housed in Module 4C, cell 4 on 08-30-25 at about 2:42am with two cellmates, both classified as Level 3. Curren entered the module and carried his mattress to cell 4. Curren's cellmates described him a confused, shaking and unable to climb onto the top bunk, prompting them to put his mattress on the ground. Per Body Worn Camera (BWC), at about 7:58am, deputies conducted a cell inspection/safety check of cell 4 confirming both the intercom and water were operating. During the inspection, Curren's cellmates told deputies Curren needed help. When deputies asked Curren what he needed help with, Curren was unable to articulate, ultimately saying, "*I don't know.*" At the time of the conversation, Curren was alert but laying on top of his mattress on the floor. Deputies explained to Curren they could not help him if he did not tell them what he needed help with and told him he could speak with the nurse at medication pass. DSB P&P I.64, Safety Checks stated, "*Sworn staff will conduct safety checks of incarcerated persons, housing areas, holding areas and vacant cells through direct visual observation (i.e., direct personal view of the incarcerated person/area without the aid of audio/video equipment). Safety checks of incarcerated persons consist of looking at the incarcerated persons for any obvious signs of medical distress, trauma or criminal activity.*" At about 8:34am, Curren wandered around the module during dayroom before entering the shower while wearing his clothes. IP 2 described that Curren, "*went to the shower without his soap and all that stuff in his full uniform and hit the water like he was gonna shower fully clothed without his towel*" and said, "*that's why I thought he was off.*" Per CCTV footage, IP 2 found Curren in the shower and directed him to stand in line for medication pass. At about 9:04am, one of Curren's cellmates was involved in an altercation with an unidentified IP during dayroom prompting Curren's cell to be locked down the remainder of the day. Safety checks were conducted within policy timelines with the final one occurring at about 2:48pm. Per statements from Curren's cellmates, shortly after the last safety check, Curren began choking and spitting. According to their statements, the cellmates activated the intercom in their cell however it was not answered. See Allegation 4. About thirty seconds after activating the intercom, Curren's face began turning blue prompting the cellmates to again use the intercom and pound on their cell door to request help from IP's who were in the dayroom. IPs in the dayroom retrieved Naloxone from within the module and began pounding on the module door to get deputies attention. According to the cellmates, they each performed CPR compressions while IPs outside the door counted for them. Per CCTV, deputies made entry into the module about one minute and 39 seconds after IP's were alerted to the medical emergency. Deputies made entry into the cell, observed Curren blue in the face and requested immediate medical assistance via radio. Deputies removed Curren from the cell and began lifesaving measures including CPR and administration of Naloxone. DSB P&P M.5, Medical Emergencies said, "*All facility staff shall be responsible for taking appropriate action in recognizing, reporting or responding to an incarcerated person's emergency medical needs. In any situation requiring medical response, emergency medical care shall be provided with efficiency and speed without compromising*

security.” Medical staff began arriving within one minute of the request and continued lifesaving measures including an AED. San Diego Fire Department personnel arrived at about 3:16pm, continued lifesaving measures, and transported Curren to Mercy Hospital where he was pronounced dead. Per the Medical Examiner’s report, Curren *“died as a result of the complications of hypertensive cardiovascular disease in the setting of a hypoplastic right kidney.”* Contributing factors to the death were, *“Asthma, chronic ethanol use and obesity.”* The manner of death was, *“natural.”* Pursuant to CLERB Rules and Regulations 16.1, upon conclusion of review by the full Board, CLERB shall deliberate and adopt a final report containing findings of fact and an overall conclusion as specified in 16.2.

2. Misconduct/Procedure – Deputies 1 and 2 failed to refer IP Curren to medical personnel.

Board Finding: Pending

Staff Recommended Finding: Unfounded

Rationale: The investigation revealed that Curren’s cellmates told deputies he needed assistance during a cell inspection. On 08-30-26 around 7:58am, Deputies 1 and 2 conducted a cell inspection of IP Curren’s cell. Per BWC footage, at the time of the inspection, Curren was laying on his mattress on the floor, IP 1 was sitting on a stool, and IP 2 was laying in the middle bunk. IP 1 told deputies Curren was shaking and having trouble moving. Deputy 1 asked Curren, *“Are you taking medication, do you need to see the nurse, what do you need?”* Curren answered, *“No, im just uh god damn it.”* Deputy 1 asked Curren three times in various ways if he needed help and what he needed help with. Curren was lying down with his hand behind his head, alert and looking around but did not answer. IP 2 relayed that Curren would only say, *“I don’t know”* whenever he or IP 1 asked also. Deputy 1 replied, *“Ok so I’m not a medical professional if he doesn’t know if he needs help so when the nurse comes here, you can voice your concerns”* and ended the cell inspection. DSB P&P I.64, Safety Checks said, *“Sworn staff will conduct safety checks of incarcerated persons, housing areas, holding areas and vacant cells through direct visual observation (i.e., direct personal view of the incarcerated person/area without the aid of audio/video equipment). Safety checks of incarcerated persons consist of looking at the incarcerated persons for any obvious signs of medical distress, trauma or criminal activity.”* DSB P&P M.15, Medical Emergencies said, *“Incarcerated persons in need of urgent medical attention shall be immediately referred to health staff.”* At about 8:39am, Curren stood in line for medication pass and received two of his prescribed medications from medical staff. There was no evidence that Curren voiced concerns to medical staff during medication pass. The evidence shows that the alleged act or conduct did not occur.

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

Board Finding: Pending

Staff Recommended Finding: Unfounded

Rationale: Due to timing of Curren’s medical emergency, the preceding safety check was specifically investigated to determine if applicable SDSO policies were followed. On 08-30-26, Deputies 1 and 2 conducted a safety check at about 2:48pm, approximately fifteen minutes before Curren suffered a medical emergency. Per CCTV and BWC footage, deputies did not note any issues within the cell. Per BWC, there appeared to be no emergency taking place and one of Curren’s cellmates can be seen laying in his bunk. According to CCTV at about 3:06pm, unidentified IPs in the dayroom responded to Curren’s cell. Per statements from Curren’s cellmates, they summoned help by activating the intercom and by getting the attention of IPs in the dayroom when they noticed Curren turn blue and stop breathing. DSB P&P I.64, Safety Checks said, *“Sworn staff will conduct safety checks of incarcerated persons, housing areas, holding areas and vacant cells through direct visual observation (i.e., direct personal view of the incarcerated person/area without the aid of audio/video equipment). Safety checks of incarcerated persons consist of looking at the incarcerated persons for any obvious signs of medical distress, trauma or criminal activity.”* The evidence shows that the alleged act or conduct did not occur.

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

Board Finding: Pending

Staff Recommended Finding: Not Sustained

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

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

Board Finding: (Adopted/Deferred)

Conclusion: This case was reviewed in accordance with CLERB Rules & Regulations 4.3.a, Complaint Not Required: Jurisdiction with Respect to Specified Incidents. See Rationale 1. Per the Medical Review Report, there were no deviations from the established standards of care identified in the evidence reviewed. The staffing level for medical personnel was appropriate to the size of San Diego Central Jail (SDCJ). SDSO MSD Number A.3.1 Medical Autonomy said, "Health care decisions are made by qualified health care professionals for clinical purposes. Ultimately, the qualified health provider is responsible for the appropriate management of the patient." The medical response to Curren's emergency was rapid and the lifesaving actions taken were appropriate. DSB P&P M.5, Medical Emergencies said, "All facility staff shall be responsible for taking appropriate action in recognizing, reporting or responding to an incarcerated person's emergency medical needs. In any situation requiring medical response, emergency medical care shall be provided with efficiency and speed without compromising security." CLERB Rules & Regulations 16.1, at the conclusion of a matter before the entire CLERB, CLERB shall deliberate and adopt a final report ("Final Report") with respect to the case or matter under consideration. This report shall include Findings as to the facts relating to any case, as well as an overall conclusion as to any case as specified in Section 16.2.

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

Board Finding: Pending

Expert Recommended Finding: Unfounded

Rationale: The complainant reported medical staff failed to conduct a thorough evaluation of Curren at intake. See Rationale 1. Per the Medical Review Report, the medical intake process was performed in a timely manner with the necessary relevant information captured. Curren appeared stable upon initial screening and was noted as having a history of asthma and depression. Curren's vital signs were within normal limits, and no suicidal ideations were presented. No evidence that would have alerted medical staff to the need for special placement or for more urgent evaluation was noted. MSD P&P E.2.1 Medical Clearance said, "a documented clinical assessment of medical, dental, and mental status before an individual is admitted into the facility. The medical clearance may come from on-site health staff or may require sending the individual to the hospital emergency department (ED). Receiving Screening – A process of structured inquiry and

observation intended to identify potential emergency situations among new arrivals and to ensure that patients with known illnesses and those on medications are identified for further assessment and continued treatment. Medication-Assisted Treatment (MAT) – the use of medications in combination with counseling and behavioral therapies to provide a “whole patient” approach to the treatment of substance use disorders.” The investigation clearly established that the allegation is not true.

25-116/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/Deferred

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: Pending

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 hours." 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 disclosed evidence sufficient to prove the allegation by a Preponderance of the Evidence.

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

Board Finding: Pending

Staff Recommended Finding: Sustained

Rationale: See Rationale 1. On 10-02-25 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 disclosed evidence sufficient to prove the allegation by a Preponderance of the Evidence.

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

Board Finding: Pending

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 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.)."* Deputies 1 and 3 provided confidential statements during CLERB's investigation that were taken into consideration. The investigation failed to disclose sufficient evidence to clearly prove or disprove the allegation.

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

Board Finding: Pending

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 SDO 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 SDO 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 1.64 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 disclosed evidence sufficient to prove the allegation by a preponderance of the 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: Pending (Adopted/Deferred)

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: Pending

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 disclosed evidence sufficient to prove the allegation by a Preponderance of the Evidence.

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: Pending

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: Pending

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: Pending

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.... CLERB lacks jurisdiction.

26-129/KERR

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

Board Finding: Pending

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.... CLERB lacks jurisdiction.

End of Report