MONICA MONTGOMERY STEPPE

SUPERVISOR, FOURTH DISTRICT
SAN DIEGO COUNTY BOARD OF SUPERVISORS

AGENDA ITEM

DATE: **December 10, 2024** **35**

TO: Board of Supervisors

SUBJECT
IMPROVING PUBLIC SAFETY THROUGH EFFECTIVE CIVILIAN OVERSIGHT OF LAW ENFORCEMENT (DISTRICTS: ALL)

OVERVIEW
According to the California State Auditor's report released in February 2022, San Diego County ("County") had the highest rate of in-custody deaths among all counties in the state of California between the years 2006–2020.[1] Concerningly, the jail death rate continued to increase after the report's subject period: the in-custody death rate nearly doubled in 2021–2022 from 2.4 deaths per 1,000 average daily population ("ADP") to 4.6, largely driven by a spike in drug overdoses—often fentanyl. Recent changes to state law and in the Sheriff's policies have addressed some of the underlying causes for the high number of in-custody deaths, and the number of such deaths in 2024 is set to be significantly lower compared to previous years. But there is more the County can do.

The State Auditor's Report identified deficiencies in how the County's Citizens Law Enforcement Review Board ("CLERB") has conducted investigations of jail deaths. The Report found that CLERB failed to investigate nearly a third of all custodial deaths between 2006 and 2017. For example, CLERB dismissed investigations of 13 in-custody deaths that occurred between 2011 and 2016 because the investigations exceeded the one-year time limit on investigations of peace officer misconduct set by the Police Officers' Bill of Rights ("POBR"), Cal. Gov't Code § 3304(d). The Report concluded that this was because CLERB first "learned in 2017 that the one-year time limit also applied to investigations of deaths." The Report also found that many custodial deaths caused by deficient medical care were insufficiently investigated because CLERB lacks authority to investigate persons other than sworn peace *officers* and therefore cannot investigate the alleged misconduct of healthcare providers working in County jails.

CLERB is a *law enforcement* review board, and the provision of medical care is often not thought of as a traditional law enforcement function. However, the Sheriff and Probation are

[1] Auditor of the State of California, Report No. 2021-109, San Diego County Sheriff's Department: It Has Failed to Adequately Prevent and Respond to the Deaths of Individuals in Its Custody [hereinafter "State Auditor's Report" or "Report"] (2022), https://www.auditor.ca.gov/pdfs/reports/2021-109.pdf/.

constitutionally obligated to provide adequate healthcare to detained persons in their custody. Providing medical care to incarcerated persons is therefore a law enforcement function that should fall within CLERB's purview as a law enforcement oversight body. Recent legislative changes at the state level and policy changes within the Sheriff's Office have decreased jail deaths in 2024,[2] continuing the declining trend beginning in 2023. Nonetheless, the County should implement various reforms to CLERB to allow the agency to more effectively carry out its critical task of independently investigating misconduct and deaths of individuals in the custody of County law enforcement agencies.

This is a request to amend County laws governing CLERB to address past deficiencies and make CLERB an effective law enforcement oversight board. At a high level, this is a request for the Board of Supervisors ("Board") to direct the County Administrative Officer and County Counsel to do the following:

- Draft an amended ordinance which would
  - expand CLERB's jurisdiction, only in the case of an in-custody death, to investigate **any** employee or contractor working under the direction of the Sheriff or Probation, including contracted health care providers;
  - implement a reporting requirement as an accountability mechanism to ensure that CLERB completes investigations within one year of when it discovers allegations of misconduct, consistent with state law, *see* Cal. Gov't Code § 3304(d) (the Police Officer's Bill of Right, or "POBR");
  - require CLERB to prioritize investigations of incidents involving death over all other investigations;
  - require CLERB to investigate all in-custody deaths, including those classified as "natural"; and
  - provide CLERB with jurisdiction to reopen a closed case, in narrow circumstances, if the requirements of California Government Code section 3304(g) are met.
- Estimate the cost and staffing needs of expanding CLERB's jurisdiction as outlined above.
- Produce a comparative analysis which identifies civilian oversight boards in other jurisdictions and their approach to investigating health care providers working under law enforcement agencies and comparing those models to this proposal.

RECOMMENDATION(S)
SUPERVISOR MONICA MONTGOMERY STEPPE

1. Direct County Counsel to draft an amended ordinance making the following changes to San Diego County Administrative Code §§ 340–340.15 relating to the Citizens Law Enforcement Review Board ("CLERB"):
   a. In the event of the death of any individual which occurs while the individual was in the custody of the Sheriff's Office ("the Sheriff") or the Probation Department ("Probation"), or occurs within six months of that individual's release from custody

[2] According to the Sheriff, there have been a total of 7–8 jail deaths so far in 2024, putting the County on track to report the lowest number of yearly jail deaths since 2012. *See* State Auditor's Report at 14 (showing San Diego County jail deaths for each year between 2006 and 2021).

pursuant to "compassionate release" (*see* Cal. Gov't Code §§ 26605.5, 26605.6), CLERB shall have the jurisdiction to investigate **any** peace officer, custodial officer, employee, or contractor—including any contracted health care provider—working under the direction of the Sheriff or Probation. As part of any investigation of a health care provider, CLERB shall consider whether the health care provider's function in the detention facility was adequately staffed at the time the incident under investigation took place.

b. Consistent with the one-year investigatory time limit set by California Government Code § 3304(d) (the Police Officer's Bill of Right, or "POBR"), it shall be the policy of CLERB to complete all investigations of alleged misconduct **within one year of the date on which CLERB discovers the alleged misconduct**. If CLERB fails to complete an investigation within one year or anticipates that it will fail to complete the investigation within one year, the Executive Officer of CLERB shall report to the Board of Supervisors within thirty days after the one-year limit has run on: (i) whether the one-year time limit prescribed by California Government Code § 3304(d) governing investigations of sworn officers applies; (ii) if the one-year limit applies, whether any tolling provision listed under California Government Code § 3304(d)(2) applies; and, (iii) if no tolling provision listed under California Government Code § 3304(d)(2) applies, a succinct explanation of any reasons why the investigation could not be completed within one year. Under no circumstance will CLERB dismiss an investigation or complaint involving a death due to inability to complete the investigation within the time limit prescribed by POBR.

c. CLERB shall prioritize investigations of incidents involving death over all other investigations. CLERB shall promulgate its own regulation on the prioritization of other types of investigations.

d. Pursuant to San Diego County Administrative Code § 340.9(b)(1), CLERB shall investigate all in-custody deaths, including those classified as "natural."

e. CLERB shall have jurisdiction to reopen a case if the requirements of California Government Code section 3304(g) are met, if applicable.

2. Direct the Chief Administrative Officer to estimate the cost, staffing, and contract needs of expanding CLERB's jurisdiction to investigate **any** peace officer, custodial officer, employee, or contractor—including any contracted health care provider—working under the direction of the Sheriff or Probation in cases involving in-custody deaths.
3. Direct the Chief Administrative Officer to identify civilian law enforcement oversight boards in other jurisdictions, if any, that allow for investigations of medical providers working in jails or prisons, and to produce a comparative analysis of different models in different jurisdictions.
4. Direct the Chief Administrative Officer to engage in the meet and confer process with labor organizations affected by the reforms outlined in Recommendation 1.
5. Request CLERB to update its rules and regulations to reflect the changes outlined in Recommendation 1, and report back to the Board of Supervisors within 60 days with the proposed rules and regulations.
6. Direct County Counsel to report back to the Board of Supervisors with an initial draft of the amended ordinance reflecting the changes outlined in Recommendation 1 within 60 days.

7. Direct the Chief Administrative Officer to report back to the Board of Supervisors on Recommendations 2–3 within 60 days.
8. Direct the Chief Administrative Officer and County Counsel to return to the Board of Supervisors with a final proposed amended ordinance, final proposed rules and regulations approved by CLERB, and any updates to the analyses conducted pursuant to Recommendations 2–3 within 30 days after CLERB has approved new rules and regulations after the meet and confer process has concluded.

EQUITY IMPACT STATEMENT
Encouraging effective civilian oversight of law enforcement demonstrates a commitment to promoting equity, justice, and inclusivity.

SUSTAINABILITY IMPACT STATEMENT
Encouraging effective civilian oversight of law enforcement will further the County of San Diego's commitment to promoting justice for all San Diegans.

FISCAL IMPACT
Funds for the actions requested are included in the Fiscal Year 2024-25 Operational Plan based on existing staff time in the San Diego County Citizens Law Enforcement Review Board and County Counsel funded by General Purpose Revenue. There will be no change in net General Fund cost and no additional staff years. There may be fiscal impacts associated with future related recommendations which staff would return to the Board of Supervisors for consideration.

BUSINESS IMPACT STATEMENT
N/A

ADVISORY BOARD STATEMENT
N/A

BACKGROUND
In 1990, voters in San Diego County enacted a ballot measure to amend the County Charter requiring the County Board of Supervisors to establish the "Citizens Law Enforcement Review Board" ("CLERB") to independently investigate complaints against officers employed by the Sheriff's Office and Probation Department. CLERB is composed of eleven volunteers from the County's five supervisorial districts—two from each district and one serving at-large. CLERB is supported by a full-time staff of nine County employees, including an Executive Officer. The section of the San Diego Administrative Code governing CLERB contains a purpose statement which states that CLERB is established "to receive and investigate specified citizen complaints and investigate deaths arising out of or in connection with activities of peace officers and custodial officers employed by the County in the Sheriff's Department or the Probation Department." San Diego Cnty. Admin. Code § 340. In addition, CLERB is responsible for making "appropriate recommendations relating to matters within its jurisdiction," "report[ing] its activities," and "provid[ing] data in respect to the disposition of citizen complaints received by the Citizens Law Enforcement Review Board." *Id.* CLERB lacks authority to set policy or impose discipline against officers or County employees in the Sheriff's Office and Probation Department.

In February 2022, the California State Auditor published its report on jail deaths in San Diego County which found that between 2006–2020, San Diego County had the highest rate of in-custody deaths in the state of California. State Auditor's Report at 16. Most individuals booked in county jails are pretrial detainees who have not been convicted or sentenced. San Diego County jails had an average of 12.3 jail deaths per year between 2006–2020, and approximately 2.39/1,000 deaths per average daily population ("ADP"). *Id.* at 59. More disturbingly, after the report was published, the rate of in-custody deaths in San Diego County jails further increased. In 2021, there was a record of 18 jail deaths, which was surpassed a year later in 2022, when there were 19 jail deaths. There were 13 jail deaths in 2023. More than 25% of the jail deaths in 2021–2023 were due to drug overdoses. This spike is even more pronounced considering the decrease in ADP in the San Diego County jails following the COVID-19 pandemic from around 5,000 to 4,000, which almost doubled the normalized jail death rate from around 2.4 per 1,000 ADP to a peak of 4.4–4.6 per 1,000 ADP.

The State Auditor identified several systemic causes of the high jail death rate, including (1) failure to identify serious medical and mental health issues at booking, (2) failure to follow up on medical treatment, and (3) inadequate safety checks. Recently enacted state legislation has addressed these issues. A.B. 268 (Weber) was passed in October 2023 and went into effect on July 1, 2024. A.B. 268 implemented higher standards for screening medical and mental health conditions at booking, providing timely medical care, and conducting safety checks of incarcerated persons.

Relevant here, the State Auditor's Report also found deficiencies in how CLERB has conducted investigations of jail deaths. The Report found that CLERB failed to investigate nearly a third of all custodial deaths between 2006 and 2017. For example, CLERB dismissed investigations of 13 in-custody deaths that occurred between 2011 and 2016 because the investigations exceeded the one-year investigatory time limit set by the Police Officers' Bill of Rights ("POBR"), Cal. Gov't Code § 3304(d).[3] The Report concluded this was because CLERB first "learned in 2017 that the one-year time limit also applied to investigations of deaths." State Auditor's Report at 47.

The State Auditor found that CLERB also failed to investigate an additional 40 in-custody deaths classified as "natural" between 2006 and 2016. The Report explained:

> CLERB … did not review deaths classified as natural during this period because its former executive officers generally interpreted its jurisdiction over in-custody deaths to exclude these types of deaths. In fact, CLERB's rules and regulations do not clearly specify whether CLERB should investigate natural deaths. … Since 2017 CLERB has been consistently reviewing natural deaths. However, the lack of specificity in its rules and regulations could result in CLERB reverting to its past practice in the future.

State Auditor's Report at 47.

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[3] In 1997, the California legislature enacted the Police Officers' Bill of Rights ("POBR") which provides that with certain exceptions, a peace officer generally may not be disciplined if a public agency's investigation of the officer's alleged misconduct lasts longer than one year. Cal. Gov't Code § 3304(d). Because CLERB is a "public agency," POBR applies to CLERB's investigations. No disciplinary action may be taken in response to the findings of a CLERB investigation unless the investigation is completed within one year of when CLERB first discovered the alleged misconduct underlying the investigation.

Further, many cases involving misconduct of healthcare providers within the jails were insufficiently investigated because CLERB lacks jurisdiction to investigate persons other than peace *officers*. Although CLERB is a *law enforcement* review board and the provision of medical care is not thought of as a traditional law enforcement function, the Sheriff and Probation are constitutionally obligated to provide adequate healthcare to detained persons in their custody.[4] The provision of medical care to incarcerated persons in jails is therefore a law enforcement function and should fall within CLERB's purview as a law enforcement oversight body. While recent changes in state law and in the Sheriff's policies appear to have further decreased jail deaths in 2024,[5] continuing a declining trend starting in 2023, the County can implement additional reforms to enable CLERB to more effectively carry out its important function of independently investigating law enforcement misconduct and deaths of individuals detained in the custody of County law enforcement agencies.

This is a request to amend County laws governing CLERB to address past deficiencies and make it an effective law enforcement oversight board. Specifically, this is a request for the Board of Supervisors ("Board") to direct County staff to make the following changes to CLERB:

a. In the event of the death of any individual which occurs while the individual was in the custody of the Sheriff's Office ("the Sheriff") or the Probation Department ("Probation"), or occurs within six months of that individual's release from custody pursuant to "compassionate release" (*see* Cal. Gov't Code §§ 26605.5, 26605.6), CLERB shall have the jurisdiction to investigate **any** peace officer, custodial officer, employee, or contractor—including any contracted health care provider—working under the direction of the Sheriff or Probation. As part of any investigation of a health care provider, CLERB shall consider whether the health care provider's function in the detention facility was adequately staffed at the time the incident under investigation took place.
b. Consistent with the one-year investigatory time limit set by California Government Code § 3304(d) (the Police Officer's Bill of Right, or "POBR"), it shall be the policy of CLERB to complete all investigations of alleged misconduct **within one year of the date on which CLERB discovers the alleged misconduct**. If CLERB fails to complete an investigation within one year or anticipates that it will fail to complete the investigation within one year, the Executive Officer of CLERB shall report to the Board of Supervisors within thirty days after the one-year limit has run on: (i) whether the one-year time limit prescribed by California Government Code § 3304(d) governing investigations of sworn officers applies; (ii) if the one-year

[4] Constitutional principles "establish the government's obligation to provide medical care for those whom it is punishing by incarceration." *Estelle v. Gamble*, 429 U.S. 97, 103 (1976). "[D]eliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain' proscribed by the Eighth Amendment." *Id.* at 104 (quoting *Gregg v. Georgia*, 428 U.S. 153, 173 (1976) (joint opinion of Stewart, Powell, and Stevens, JJ.)). For pretrial detainees who have not been convicted of a crime, the right to adequate medical care arises under the Fourteenth Amendment's Due Process Clause. *See Bell v. Wolfish*, 441 U.S. 520, 535 n.16 (1979) ("Where the State seeks to impose punishment without [a formal adjudication of guilt], the pertinent constitutional guarantee is the Due Process Clause of the Fourteenth Amendment.").

[5] According to the Sheriff, there have been a total of 7–8 jail deaths so far in 2024, putting the County on track to report the lowest number of yearly jail deaths since 2012. *See* State Auditor's Report at 14 (showing San Diego County jail deaths for each year between 2006 and 2021).

limit applies, whether any tolling provision listed under California Government Code § 3304(d)(2) applies; and, (iii) if no tolling provision listed under California Government Code § 3304(d)(2) applies, a succinct explanation of any reasons why the investigation could not be completed within one year. Under no circumstance will CLERB dismiss an investigation or complaint involving a death due to inability to complete the investigation within the time limit prescribed by POBR.

c. CLERB shall prioritize investigations of incidents involving death over all other investigations. CLERB shall promulgate its own regulation on the prioritization of other types of investigations.
d. Pursuant to San Diego County Administrative Code § 340.9(b)(1), CLERB shall investigate all in-custody deaths, including those classified as "natural."
e. CLERB shall have jurisdiction to reopen a case if the requirements of California Government Code section 3304(g) are met, if applicable.

An explanation of these recommendations follows.

a. Expand Investigatory Jurisdiction in Cases of In-Custody Deaths

CLERB's investigations of in-custody deaths have been incomplete because CLERB has lacked authority to investigate misconduct of any jail staff other than sworn officers.

For example, CLERB case no. 22-080 (Granillo) involved a 25-year-old woman at Las Colinas Detention Center who died due to complications related to untreated drug withdrawal. The decedent was wrongly arrested and booked into custody for alleged violation of an expired restraining order. The decedent presented with symptoms of alcohol and opiate addiction which jail staff allegedly failed to treat. Four days after she was booked at the jail, the decedent was found unresponsive in her cell with shallow breathing and a faint pulse. Custodial officers removed the decedent from her cell and her pulse may have stopped. There were alleged delays in administering proper medical care. She was taken to a hospital where she underwent emergency surgery to repair a perforated ulcer in her stomach. However, she died the next day, and the medical examiner opined that her cause of death was septic shock and anoxic brain injury. On January 30, 2024, CLERB summarily dismissed allegations of misconduct against jail healthcare workers and concluded it lacked jurisdiction to investigate the allegations because CLERB has jurisdiction to investigate sworn officers only. CLERB's inability to complete a thorough investigation has left many questions unanswered about the circumstances of the decedent's death.

Another recent example is CLERB case no. 22-031 (Rupard), which involved a 47-year-old man at the San Diego Central Jail who died due to complications stemming from untreated severe schizoaffective disorder. The decedent was arrested on a parole violation and booked in the San Diego Central Jail. Jail staff allegedly knew of his history of severe psychiatric disorders and did not administer his medications until 10 days after he was booked. The decedent did not take the prescribed medications, and the psychiatrist discontinued the medications. Jail staff kept the decedent in general housing and did not move him into the jail's psychiatric care facility. The decedent allegedly demonstrated increasingly severe symptoms of psychiatric distress and frequently refused to eat. After 85 days in custody, the decedent allegedly lost 60 pounds, or 36% of his total body weight, and his cell was covered in trash and feces. A court-ordered psychiatrist

visited the decedent to determine his competency to stand trial. The psychiatrist noted that his cell was filthy and full of trash and was unable to have a coherent conversation with the decedent. The psychiatrist recommended transfer to state hospital and involuntary administration of antipsychotic medications as allowed by law. This never occurred, and three days later, the decedent was found dead in his cell. The medical examiner determined his cause of death to be pneumonia, malnutrition, and dehydration, and ruled his death a homicide because his severe untreated psychiatric illness rendered him dependent upon others for care. CLERB's lack of jurisdiction to investigate persons other than sworn officers has resulted in an incomplete investigation into the circumstances surrounding the decedent's death.

In a communication dated February 6, 2024, CLERB noted that it had approved changes to its rules and regulations to expand its jurisdiction to include "any person providing medical care or mental health services in County detention facilities," and to recommend that the Board of Supervisors approve such a change. The State Auditor recommended a similar change. Recommendation 1(a) in this Board Letter would implement this change limited to cases of in-custody deaths only to ensure a more manageable expansion in CLERB's capacities. The Board may consider further expansion in the future if this initial expansion is successful. This recommendation also requires CLERB to consider as part of any investigation of a health care provider whether the function of the health care provider in the detention facility was adequately staffed at the time the incident under investigation took place.

b. Implement Reporting Requirement as Accountability Mechanism

The State Auditor's Report noted that in the past—specifically, around 2017—CLERB has summarily dismissed many jail death complaints on the ground that the investigations lasted longer than the one-year period allowed by POBR. This has resulted in a significant number of jail deaths going uninvestigated. The reporting requirement proposed here would implement a policy requiring CLERB to complete all investigations (not only jail death cases) within one year to ensure that the investigations can lead to appropriate discipline when appropriate.

This proposal also provides an incentive for complying with the one-year policy by requiring CLERB to publicly report cases where the one-year deadline is missed. It would require CLERB to report to the Board of Supervisors within thirty days after the one-year limit has passed on: (i) whether the one-year time limit prescribed by California Government Code § 3304(d) governing investigations of sworn officers applies; (ii) if the one-year limit applies, whether any tolling provision listed under California Government Code § 3304(d)(2) applies; and, (iii) if no tolling provision listed under California Government Code § 3304(d)(2) applies, a succinct explanation of any reasons why the investigation could not be completed within one year. For reference, California Government Code § 3304(d)(2) tolls POBR's one-year limit in the following circumstances:

> (A) If the act, omission, or other allegation of misconduct is also the subject of a criminal investigation or criminal prosecution, the time during which the criminal investigation or criminal prosecution is pending shall toll the one-year time period.
> (B) If the public safety officer waives the one-year time period in writing, the time period shall be tolled for the period of time specified in the written waiver.

(C) If the investigation is a multijurisdictional investigation that requires a reasonable extension for coordination of the involved agencies.
(D) If the investigation involves more than one employee and requires a reasonable extension.
(E) If the investigation involves an employee who is incapacitated or otherwise unavailable.
(F) If the investigation involves a matter in civil litigation where the public safety officer is named as a party defendant, the one-year time period shall be tolled while that civil action is pending.
(G) If the investigation involves a matter in criminal litigation where the complainant is a criminal defendant, the one-year time period shall be tolled during the period of that defendant's criminal investigation and prosecution.
(H) If the investigation involves an allegation of workers' compensation fraud on the part of the public safety officer.

Finally, this proposal requires CLERB to complete all investigations involving death even when the investigations span beyond POBR's one-year time limit. It bars CLERB from summarily dismissing cases solely on the ground that the investigation has run past POBR's time limit.

c. Require CLERB to Prioritize Cases Involving Death

In its communication dated February 6, 2024, CLERB noted it had approved changes to its rules and regulations to mandate that cases involving a death be prioritized above all other cases. The State Auditor recommended such a change as well. This action would implement this change.

d. Require CLERB to Investigate All In-Custody Deaths Including "Natural" Deaths

In its communication dated February 6, 2024, CLERB noted it had approved changes to its rules and regulations to clarify that CLERB is required to investigate all deaths "including deaths determined to be due to natural causes." The State Auditor recommended such a change as well. This action would implement this change.

e. Permit CLERB to Reopen Closed Cases Consistent with Government Code § 3304(g)

In its communication dated February 6, 2024, CLERB noted it had approved changes to its rules and regulations to provide that a case "may be re-opened for reconsideration by CLERB if the requirements of Government Code section 3304(g) are met, if applicable." California Government Code § 3304(g) creates an exception to POBR's default one-year investigatory limit in narrow circumstances, and states:

(g) Notwithstanding the one-year time period specified in subdivision (d), an investigation may be reopened against a public safety officer if both of the following circumstances exist:

(1) Significant new evidence has been discovered that is likely to affect the outcome of the investigation.
(2) One of the following conditions exist:

(A) The evidence could not reasonably have been discovered in the normal course of investigation without resorting to extraordinary measures by the agency.
(B) The evidence resulted from the public safety officer's predisciplinary response or procedure.

This proposal implements this change, which CLERB has already approved. It would permit CLERB to reopen an investigation beyond the one-year limit in narrow circumstances when material new evidence has been discovered consistent with the requirements of Government Code § 3304(g).

LINKAGE TO THE COUNTY OF SAN DIEGO STRATEGIC PLAN
Today's proposed action aligns with the Equity and Empower Strategic Initiatives in the County of San Diego's 2024-2029 Strategic Plan.

Respectfully submitted,

MONICA MONTGOMERY STEPPE
Supervisor, Fourth District

ATTACHMENT(S)
N/A