SACRAMENTO COUNTY

Office of Inspector General

2020 Annual Report

Mark Evenson
Inspector General

Contents

Executive Summary

The Office of Inspector General (OIG) is an independent monitor who provides oversight of investigations of citizen complaints against the Sacramento County Sheriff's Office (SSO) to ensure they are objective, fair, and complete. The OIG informs and advises the Board of Supervisors, the Sheriff, and the County Executive relative to findings and recommendations. In addition to the citizen complaint process, the OIG is responsible for examining policies and procedures within the Sheriff's Office and providing recommendations to ensure those policies and procedures are compliant with national best practices.

With COVID-19, 2020 has been a challenging year. Physical inspections of facilities and some investigation reviews have been limited, and the complete analysis of some focus areas has been difficult. However, even with these challenges, the SSO staff has been open, professional, cooperative, and accommodating with the OIG. The SSO has been very responsive to requests and has provided information to the OIG in a timely and productive manner.

In 2020, the OIG received a total of 155 citizen complaints and inquiries. Of that total, 79 were allegations of misconduct. Those misconduct complaints were forwarded to the Sheriff's Office Internal Affairs Bureau for investigation. 48 were inquires that did not involve a report of misconduct and were handled by the OIG. 21 involved employees of another jurisdiction, and seven were related to inmate medical treatment and were forwarded to Correctional Health Services (CHS). The SSO processed a total of 332 citizen and internal complaints.

There was a total of three Officer Involved Shootings and six In-Custody Deaths that occurred in 2020. At the time of this report, those investigations were still open and being reviewed by the Sacramento County District Attorney's Office (DA). Since the DA has not yet rendered a decision in these cases, the review of those cases will not be included in the 2020 report. It is anticipated that the DA will complete their reviews in 2021, and these cases will be summarized in the OIG's 2021 Annual Report. However, in this report, there will be summaries of prior Officer Involved Shootings and In-Custody Deaths that were not previously included in past OIG reports.

The OIG reviewed a number of high-profile investigations to ensure they were conducted objectively, fairly, and completely. Of those reviews, two cases were returned to the SSO for further investigation. Overall, the OIG found that most investigations were conducted correctly, and SSO staff were diligent in their investigative efforts. Based on investigation reviews, feedback from the community, analysis of agency policies and procedures, and knowledge of national best practices, the OIG is making a total of **20 recommendations** within the following focus area categories: 1) Citizen Complaint Process, 2) Transparency, 3) Use of Force, 4) COVID-19 Jail Protocols, and 5) Training.

Each recommendation will include a **status indicator** as follows:

Pending (The recommendation has been received by the SSO and is being evaluated)
In Progress (The recommendation has been accepted by the SSO and being implemented)
Completed (The SSO has sufficiently completed the recommendation)
Partially Completed (The SSO has accepted and completed portions of the recommendation)
Declined (The SSO has declined the recommendation)

Background

The Sacramento County Sheriff's Department is one of the ten largest Sheriff's Offices in the United States and provides a wide range of law enforcement services to a diverse constituency of approximately 1.4 million people. The jurisdiction encompasses nearly 1,000 square miles, with environments ranging from dense urban communities to sprawling ranchland. The Sheriff, an elected official, is responsible for over 2,000 personnel. Front line law enforcement services including emergency 911 dispatch, patrol, investigations, forensic follow up, and property are provided directly to over half a million residents. Inmate medical care is provided in-house by professionals assigned to the Correctional Health Services Division. The Sheriff provides bailiff and security services to the Superior Court, and serves legal process throughout the county. The department supplies staffing to regional homeland security task forces, and provides the security forces stationed at critical infrastructure such as the Sacramento International Airport and the Folsom Dam. Other regional services include marine patrol of 700 miles of navigable waterways, and law enforcement air support.

The primary function of the Office of Inspector General (OIG) is to ensure the integrity of the citizen complaint process for all misconduct complaints regarding employees of the Sacramento County Sheriff's Office. The Sacramento County Sheriff's Office Internal Affairs Bureau is the primary investigative body for all complaints of misconduct. However, the Inspector General will provide independent and objective review of those complaints and investigations to ensure they are conducted thoroughly, fairly, and judiciously.

In addition, the Inspector General will:

- Track and monitor high profile or serious complaint cases. Specifically, the Inspector General will monitor investigations regarding officer involved shootings where a subject is struck, significant use of force incidents, and in-custody deaths
- Make independent determinations regarding investigations
- Advise of any investigation which appears incomplete or otherwise deficient
- Serve as community and complainant liaison
- Accept citizen complaints to be forwarded for investigation
- Attend meetings of the Sheriff's Outreach Community Advisory Board
- Provide complainants with updates about the progress and outcome of the investigation
- Meet with the community in various forums
- Listen to and address public concerns about law enforcement
- Prepare and present an annual report to the Board of Supervisors, which includes statistical information, analysis of trends, identification of pervasive and emerging problems, and recommendations for improvements to law enforcement services and the citizen complaint and investigation process
- Advise the Sheriff on the establishment of an Early Interventions System (EIS) which can identify patterns of employee behavior or actions that may lead to misconduct or pose safety concerns
- Monitor or independently investigate any other matter as requested by the Sheriff or as directed by the Board of Supervisors

Citizen Complaint Process

The SSO provides a variety of ways for citizens to file complaints of employee misconduct. These include written complaint forms located at SSO facilities, by written letter, by telephone, by email, and by an online web form. Citizens can also file complaints with the OIG. Once a complaint is filed with the OIG, that complaint is logged and forwarded to the SSO Internal Affairs Bureau for investigation. Misconduct investigations can also be generated internally by the SSO when the SSO has identified possible misconduct on their own.

Once a citizen complaint is received, the SSO will categorize the complaint based on the seriousness of the allegations. Complaints involving allegations of serious misconduct, such as excessive force, criminal conduct, discrimination, false arrest, or other serious allegations, are normally investigated by the Internal Affairs Bureau. These complaints are considered Category I complaints. Category II complaints are less serious and include complaints regarding procedure violations, service delivery, discourtesy, and conduct unbecoming an officer that do not amount to Category I. These Category II complaints are usually investigated by a supervisor or manager within the named employee's division. Minor complaints that do not amount to the levels of Category I or II complaints are categorized as "Citizen Complaints." These complaints alleging minor misconduct are usually investigated by the named employee's supervisor. All three categories require that the complaints be logged into the Internal Affairs complaint software system (IA Pro) and given a complaint number. These investigations are fully logged, tracked, and documented.

Informal Complaint Resolution

As part of the OIG review and audit of the citizen complaint process, the OIG discovered that some very minor citizen complaints that are communicated directly to a supervisor by a citizen can be handled and mitigated by the involved employee's supervisor. If minor, the supervisor can speak with the complainant and involved employee(s) and work to resolve the issue to the complainant's satisfaction. If a minor complaint is resolved by the supervisor, the supervisor may decide to make a notation. If there is no indication of serious misconduct and the citizen does not demand a formal investigation, the supervisor can resolve the issue informally. The supervisor is not required to document the complaint nor report the complaint to the Professional Standards Division (PSD).

Based on best practices, early supervisory intervention in resolving minor misconduct complaints is beneficial for both the citizen complainant as well as the involved employee. This can result in higher satisfaction for the citizen and provide immediate corrective feedback to the employee to improve performance. The SSO should be applauded for being proactive in their attempts to resolve minor citizen complaints. However, the OIG believes these types of complaints should be formally tracked. All citizen complaints, however minor, should be documented. This will provide for more transparency when it comes to tracking citizen complaints, and it will provide a better system to track the important work being done by supervisors.

20-1 Recommendation – Informal Complaint Resolution

The SSO should develop a tracking and documentation system for all minor citizen complaints currently being resolved informally at the supervisory level.

Status: Pending

Internal Affairs Complaint Tracking

The OIG review process also discovered that in some instances, not all citizen complaints received by the Internal Affairs Bureau (IA) were being logged into the Citizen Complaint tracking software, IA Pro.

A few complaints that were deemed to be frivolous or incoherent were being held temporarily and then discarded without proper logging and documentation. This was brought to the attention of IA staff and corrected. All citizen complaints filed directly with the Internal Affairs Bureau are now being properly logged and documented.

20-2 Recommendation – Internal Affairs Complaint Tracking

The Internal Affairs Bureau should log and document all citizen complaints regardless of their perceived validity.

Status: Completed

Initial Complaint Reporting and Documentation

SSO Policy 3-01 Complaints and Disciplinary Policies Section III (C) states the following:

"Complaints against Department personnel received during regular business hours should be directed to Internal Affairs."

Regardless of time of day, any citizen complaint brought to the attention of SSO staff should be received, documented, and forwarded to Internal Affairs. A citizen filing a complaint regarding alleged misconduct should not be referred. Having a supervisor or watch commander speak with the complainant and document their allegations aligns with national best practices.

20-3 Recommendation – Initial Complaint Documentation

The SSO should revise policy 3-01 Section III (C) to mandate that a supervisor or watch commander document a citizen complaint and forward that complaint to the Professional Services Division for review and classification.

Status: Pending

Receipt of Complaint – Documentation

When citizens file a complaint with the agency, the responsible investigative staff has called, emailed, or sent a letter officially notifying the complainant that the complaint has been received by the SSO.

Early acknowledgement that the complaint has been received is a critical part of the citizen complaint process. It reinforces to the citizen that their complaint is being taken seriously and being reviewed in a timely manner. In some cases reviewed by the OIG, it was difficult to determine if and when the initial acknowledgement was done by staff.

To ensure that this critical communication is done for every citizen complaint, the SSO should require the responsible investigative staff (either IA or the Division) place a copy of the letter or email in the investigative file, or if it was done via phone call, the investigative staff should make note of that contact in the file.

20-4 Recommendation – Receipt of Complaints – Documentation

The SSO should require the responsible investigative staff (either IA or the Division) place a copy of the letter or email in the investigative file, or if it was done via phone call, the investigative staff should make note of that contact in the file.

Status: Pending

Providing Complainants with Status Updates

Another area of concern is communication when the complaint investigation becomes protracted or extended beyond the normal timelines. In these instances, the responsible investigative staff should provide a written status update to the complainant and place a copy of the notification in the investigative file.

20-5 Recommendation – Communication with Complainants – Status Updates

The SSO should require the responsible investigative staff provide a written status update to the complainant when investigations go beyond the normal timelines and place a copy of the notification in the investigative file.

Status: Pending

Complaints Related to Medical Treatment of Inmates

The proper care and medical treatment of incarcerated individuals is a top priority for the OIG. The OIG has found that both SSO staff in the jails and Correctional Health Services (CHS) staff have been very responsive when issues of care and medical treatment has been brought to their attention by this office. However, the OIG has found that the documentation and tracking of medical treatment complaints referred to CHS has been inadequate.

Within the Sacramento County jails, medical care and treatment is the responsibility of Correctional Health Services (CHS). When a complaint is received regarding the medical treatment and care of an inmate, that complaint is reviewed by IA to determine if there was any potential misconduct by SSO personnel.

If there are any allegations of wrongdoing by SSO staff, the complaint is handled primarily by Internal Affairs with assistance from CHS. If the complaint only involves Correctional Health Services personnel, the complaint is forwarded to CHS for follow up and investigation.

Though the response to medical treatment complaints have been satisfactory, the documentation of those complaints and investigation referred to CHS has not. To improve tracking and documentation, the SSO should work with CHS to develop a better system of referral, investigation, and documentation.

Internal Affairs (IA) should log and track medical treatment complaints referred to CHS, and CHS should track and document their follow-up actions to resolve the complaint. It is understood that HIPAA laws may not allow full disclosure of private medical information, but CHS can still log, track, and document the complaints and provide some information regarding how the complaint was resolved.

20-6 Recommendation – Complaints Related to Medical Treatment of Inmates

The SSO should work with CHS to develop a better tracking and documentation system for complaints referred to CHS by SSO related to the medical treatment and care of inmates.

Status: Pending

Misconduct Investigation Training

As discussed earlier, citizen complaints and misconduct investigations are conducted by investigators assigned to Internal Affairs and by the named employee's supervisors and/or commanders located at the division level. Newly promoted supervisors do receive some training in the area of misconduct investigations, and they are also mentored by Internal Affairs investigators.

Overall, the quality of the divisional investigations has been adequate. However, due to the ever-changing legal landscape as it relates to the investigation of employee misconduct, the OIG recommends that all supervisors and commanders receive annual refresher training on misconduct investigation procedures. This will ultimately provide for better quality and consistency of investigations.

20-7 Recommendation – Misconduct Investigation Training

All supervisors and commanders responsible for conducting citizen complaint and internal misconduct investigations should receive annual refresher training on misconduct investigation procedures.

Status: Pending

Complaints & Inquiries Received by the OIG

The following represents the method complaints and inquiries were received by the Office of Inspector General (OIG) in 2020 and how those complaints were handled. All complaints and inquiries received by the OIG are logged and documented. Complaints alleging misconduct involving Sacramento County Sheriff's Office personnel are forwarded to the Professional Standards Division (PSD) Internal Affairs Bureau for follow up and investigation.

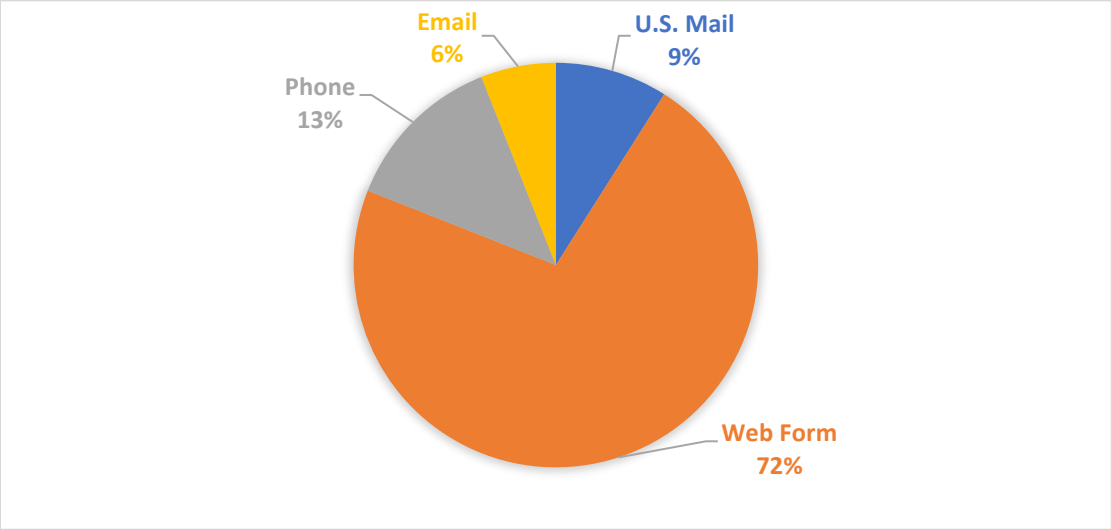
Inquiries involving non-misconduct issues are handled by the OIG. Inquiries can include requests for information, questions regarding policy and practices, complaints of misconduct that involve other agencies, and complaints regarding the medical treatment and care of inmates. The OIG also logs, documents, tracks, and reviews all Officer Involved Shootings and In Custody Deaths.

Method Received

For 2020, the Office of Inspector General received 79 complaints of misconduct by Sacramento Sheriff's Office employees, three commendations, 21 complaints of misconduct by employees of a different agency, seven complaints of medical treatment and care inside the jails, and 48 non-misconduct inquires.

The OIG received a total of **158** complaints, commendations, and inquiries for 2020. This compares to 118 in 2017. Due to the Office of Inspector General being vacant, there were no Office of Inspector General (OIG) Annual Reports for 2018 and 2019. Some of the numbers for

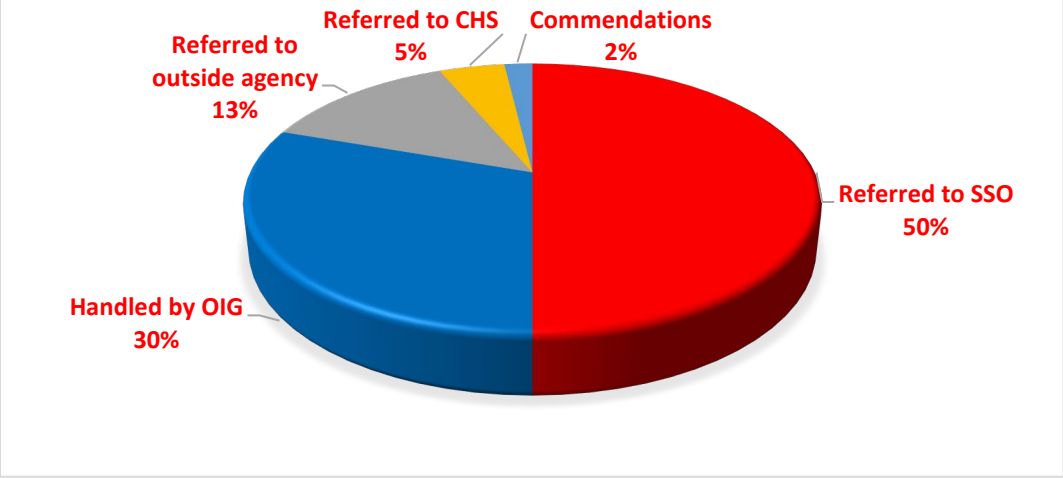
2020 include complaints and inquires that came into to OIG during the vacancy period. Due to COVID-19, there were no in-person complaints filed for 2020.



OIG Methods Received

Complaint/Inquiry Assignment

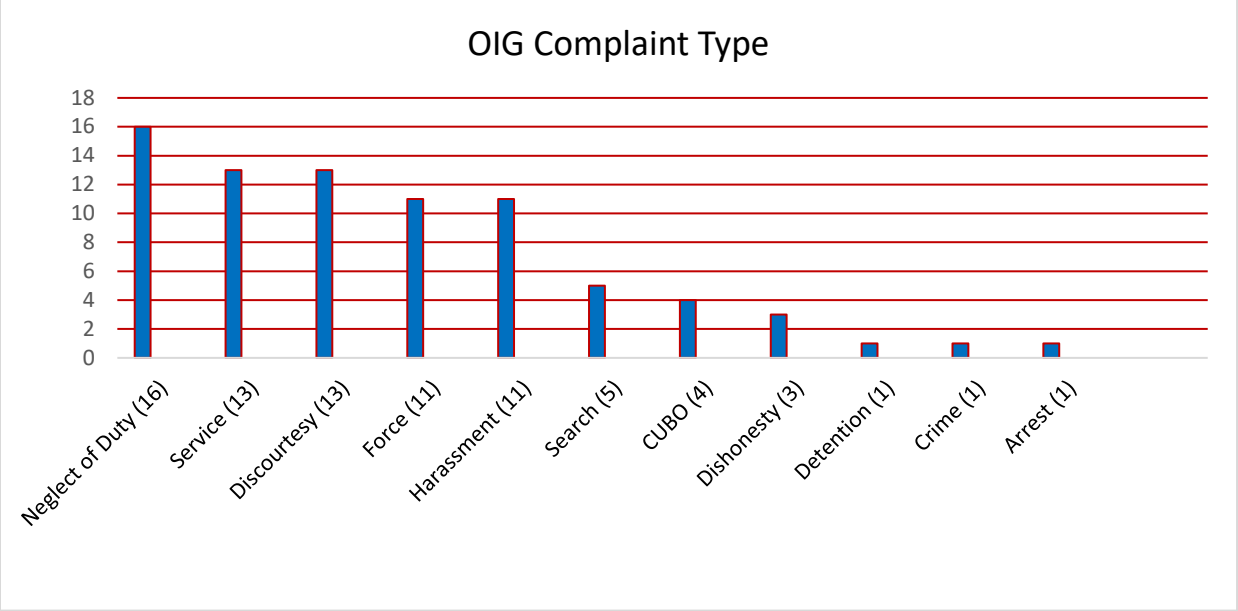
Of the 158 total complaints/inquiries received, 79 were referred to the Sheriff's Office (SSO) for investigation, 48 were handled by the Inspector General (OIG), 21 were referred to outside agencies, seven were referred to Correctional Health Services (CHS), and three commendations were forwarded to the Sheriff.



OIG Complaint Assignments

Complaint Type

In 2020, the OIG received a total of 79 citizen complaints of misconduct. These complaints were referred to the SSO for follow up and investigation. As complaints are received by the Office of Inspector General, they are assigned a complaint type based on the initial information provided. The following chart illustrates the type of complaints that were referred to the SSO in 2020.



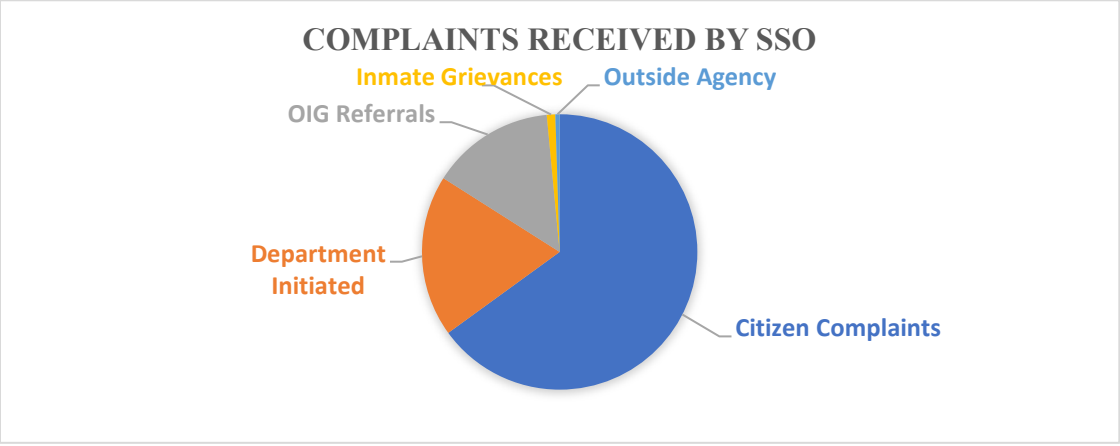
OIG Complaint Type

Complaints Received by the Sacramento Sheriff's Office

The following is information received from the Sacramento County Sheriff's Office Professional Services Division – Internal Affairs Bureau. The data includes complaints received by the Sheriff's Office from the community, complaints that are received by the OIG and forwarded to the Sheriff's Office, and complaints initiated internally by the Sheriff's Office.

Complaints Received by SSO

In 2020, the Sheriff's Office investigated 332 complaints against employees within the Department. Of the 332 complaints, 215 were citizen complaints, 63 were internally generated by the department, 48 were citizen complaints that came through the OIG, four were inmate grievances alleging misconduct, and two came from outside agencies.

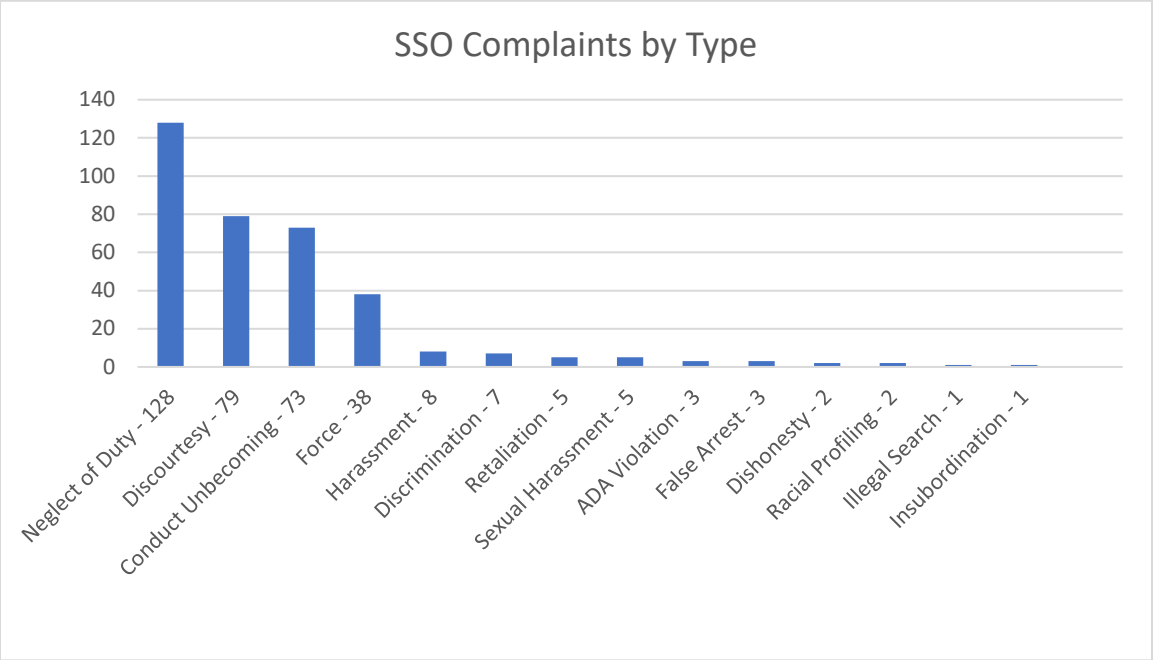


SSO Complaints Received

Note: The total number of complaints recorded by the SSO that were received by the OIG (48) is lower than the total number of citizen complaints reported as received by the OIG (79). This is because 31 of the citizen complaints received by the OIG were simultaneously submitted to the SSO. Therefore, those particular complaints were recorded as "citizen complaints" by the SSO and not "OIG Referrals."

Total SSO Complaints by Type

The 332 complaints investigated by the Sheriff's Department were broken down into 14 categories. With some complaints, more than one allegation was investigated. Therefore, types and dispositions will be higher than the total number of complaints received. The following chart represents the category of complaints the SSO investigated for 2020.



SSO Complaints by Type

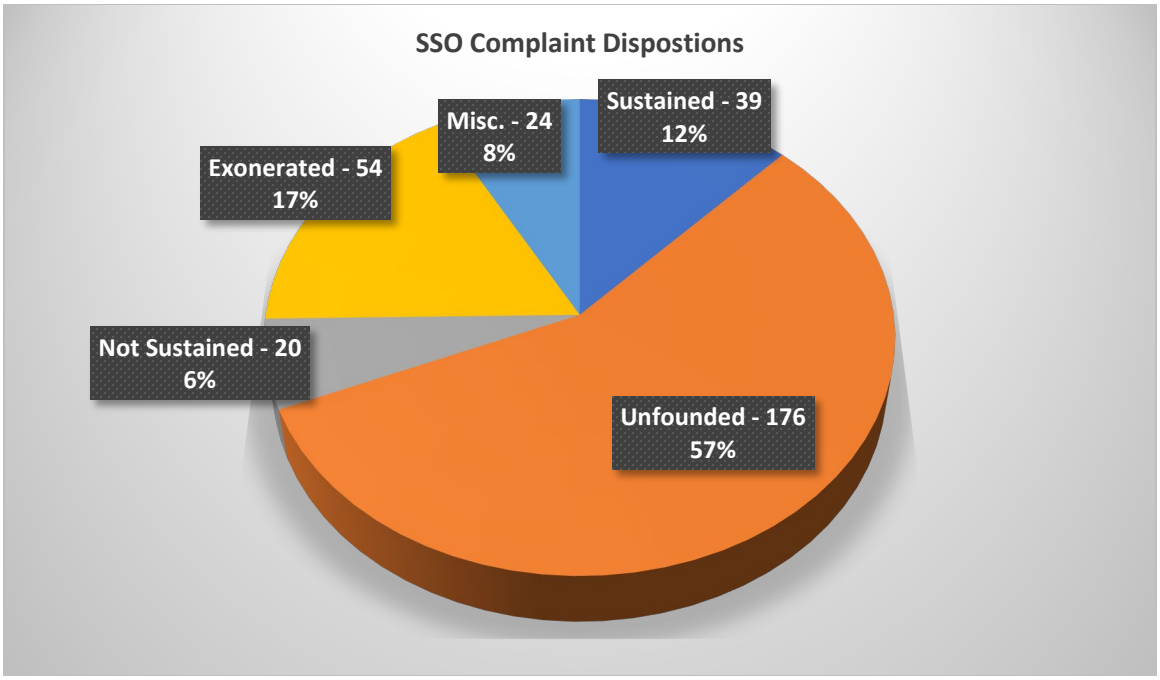
SSO Complaint Dispositions

Dispositions are classified into four primary categories with a miscellaneous category for investigations that are not completed because the complainant failed to cooperate, the complaint was withdrawn by the complainant, the complaint involved employees from another agency, or the employee resigned before the completion of the investigation.

The categories are:

- Exonerated – The incident occurred, but the employee's conduct was lawful and proper.
- Unfounded – The allegation was false, or the incident did not occur.
- Not sustained – The evidence was insufficient to prove or disprove the allegation.
- Sustained – There is evidence sufficient to support the allegation.
- Misc. – When circumstances prevent the investigation from progressing to a success.

For the 332 complaints for 2020, 19 are still open and have not yet been closed with a disposition. 313 have been closed. 176 were unfounded, 54 were exonerated, 39 were sustained, 20 were not sustained, and 24 were closed as miscellaneous.



SSO Complaint Dispositions

After reviewing cases and speaking with IA staff, the OIG has determined that there is some inconsistency in how dispositions are applied to some cases. This has caused some confusion. The SSO should examine their current practices for closing cases and assigning dispositions and revise that process to make it more consistent with national best practices.

20-8 Recommendation – Complaint Dispositions

The SSO should examine their current practices for closing cases and assigning dispositions and revise that process to make it more consistent with national best practices.

Status: Pending

Transparency

Public access to information about how law enforcement agencies make key organizational decisions and the outcomes of those decisions has the potential to increase public and organizational accountability, encourage citizen engagement, and promote trust between the police and the communities they serve.

Body Worn Cameras

Many law enforcement agencies across the country have embraced the use of body worn cameras for their officers and deputies. This technology has been instrumental in providing better transparency with the public and improving safety for the law enforcement personnel who utilize them. In early 2020, the OIG discussed body worn cameras with the Sheriff and the Board of Supervisors. Both the Sheriff and Board of Supervisors were supportive of the use of body worn cameras by SSO staff. The implementation had been delayed due to funding. In 2020, the Board of Supervisors approved funding for the body worn cameras. The SSO is currently implementing the program.

20-9 Recommendation – Body Worn Cameras

The SSO should implement a Body Worn Camera program.

Status: In Progress

Providing Information to the Public

Transparency is a critical component to help build and maintain the public's trust. Due to the nature of law enforcement, not all information is available for public consumption. However, some community members feel the SSO lacks transparency. The OIG does agree that the SSO can improve transparency by providing more legally releasable information to the public.

Though the SSO does some good work with some reports, it can do more in its efforts to become more transparent and accountable to the community. A good starting point for increasing transparency is the release of citizen complaint and investigation data to the public. This should be done on an annual basis. This information could be part of their annual report or a separate report to the public.

20-10 Recommendation – Providing Information to the Public

The SSO should provide their own annual public report outlining their citizen complaint and investigation data.

Status: Pending

SSO Online Complaint/Commendation Form

One of the ways a citizen can file a complaint directly with the SSO is to complete the online complaint/commendation form found on the Sheriff's Office website. This same tool is located on the OIG's website. The establishment of the online form made the reporting of complaints and/or commendations much more user friendly for the public.

This is an excellent tool to provide citizen's easier access to the agency. In a recent audit of the agency's website, the OIG discovered that the link to the online complaint/commendation tool was not easily found or accessible by the public. The link for the complaint/commendation form should be placed clearly on the Sheriff's Office main web page.

20-11 Recommendation – SSO Online Complaint/Commendation Form

The link for the SSO online complaint/commendation form should be placed clearly on the Sheriff's Office main web page.

Status: Pending

OIG Notification of Serious Incidents and Allegations

The Professional Standard Division and the Internal Affairs Commander have done an excellent job notifying the OIG when an officer involved shooting has occurred. However, this timely notification needs to be expanded to other types of significant events and complaints.

In addition to officer involved shootings, the OIG should be immediately notified when there is an in-custody death, force resulting in serious injury, any allegations of criminal misconduct,

and any high-profile allegation of misconduct that will likely draw the attention of the community and the media.

20-12 Recommendation – OIG Notification of Serious Incidents and Allegations

The SSO should immediately notify the OIG when there is an in-custody death, force resulting in serious injury, any allegations of criminal misconduct, and any high-profile allegation of misconduct that will likely draw the attention of the community and the media.

Status: Pending

Use of Force

Peace officers are entrusted with an enormous amount of power, including the authority to use force, and it is important that law enforcement undertake these responsibilities in a manner that is legal, ethical, and moral.

Law enforcement agencies must also promote transparency and accountability to demonstrate to the community that officers and deputies act fairly and impartially, and that there are systems in place to detect mistakes or abuses of police authority.

Public trust and cooperation are key elements of effective policing, and trust can be lost when police engage in unconstitutional or unprofessional conduct. The use of force by law enforcement has never been more scrutinized, and the review of the agency's use of force practices remains a top priority for the OIG.

After reviewing the SSO's use of force policies and procedures, the OIG has determined that the organization has strong use of force policies and procedures in place. Employees are well trained in following those policies and procedures, and SSO leadership has demonstrated a commitment to ensuring the use of force is conducted legally and within department policy.

The use of force policies and procedures provide strict guidelines for when force can be used. Force must be documented, and supervisors are required to enter force information into their use of force tracking software called "Blue Team."

The OIG has found that the agency has good accountability measures in place as it relates to the use of force. However, there are some areas for improvement as it relates to both use of force tracking and use of force review.

Tracking Use of Force Data

The tracking of use of force incidents is very important for identifying any significant trends related to the use of force, and it can also help in detecting deficiencies and training needs within the organization. In early 2020, the OIG discussed the tracking of use of force incidents with agency leadership.

Though the agency does a good job documenting all use of force incidents, retrieving specific use of force data for analysis has been difficult. The agency indicated that they have a software tracking tool called "Blue Team," and that the tool became fully operational for force tracking purposes in 2020. At the time of this report, the agency is now utilizing the tracking tool.

20-13 Recommendation – Tracking Use of Force Data

The SSO should fully utilize the "Blue Team" software to track, analyze, and report on use of force incidents.

Status: In progress

Use of Force Review Board

The SSO has a formal Use of Force Review Board in place to review all officer involved shooting incidents, in-custody deaths if the event involved the application of force, and any other significant use of force incidents that leadership identifies for review.

The Use of Force Review Board is responsible for reviewing the circumstances surrounding the events to determine if policies were properly followed or if there was misconduct involved. The Board can make recommendations to the Sheriff related to training needs, policy revisions, or the need to investigate possible misconduct. Having a Use for Force Review Board with these responsibilities does align with national best practices.

Not all law enforcement agencies have Use of Force Review Boards in place, and the SSO should be recognized for establishing this type of force review. However, The OIG was informed that these reviews are verbal only.

The OIG understands from a legal perspective that some information in the report may not be able to be released. However, it is the opinion of the OIG that all Use of Force Board reviews should be documented in writing and made available for review when legally permitted to do so.

20-14 Recommendation – Documenting Use of Force Board Reviews

The SSO should ensure all Use of Force Board reviews are documented in writing.

Status: Pending

Use for Force Analysis and Reporting

The Use for Force Board reviews serious incidents of force. Most incidents of force do not rise to that level. However, conducting a thorough analysis of all incidents of force provides the foundation for identifying trends and improving operations and accountability.

Conducting a review and analysis of all incidents of force, at least annually, does align with national best practices. The OIG did speak with the IA Commander who indicated that he does review use of force incidents and discusses them with leadership.

Having that review and dialogue is important and healthy, but this appears to be verbal and not a formal, written analysis to help identify possible systemic issues with the use of force. Now that the agency is utilizing the use of force tracking software, the SSO should conduct a full analysis of the agency's use of force and provide a written report of that analysis at least annually to the Board of Supervisors and public.

20-15 Recommendation – Use of Force Analysis

The SSO should conduct a full analysis of the agency's use of force and provide a written report to the Board of Supervisors and public at least annually.

Status: Pending

Carotid Neck Restraint

In early 2020, the OIG spoke to the Sheriff about the discontinuation of the Carotid Neck Restraint. The Sheriff had already discontinued its use. Subsequently, California passed AB-1196 banning chokeholds. The SSO's use force policy complies with AB-1196.

20-16 Recommendation – Carotid Neck Restraint

The SSO should eliminate the use of the Carotid Neck Restraint.

Status: Completed

COVID-19 Jail Protocols

A top concern in 2020, and currently, is the vulnerability of incarcerated individuals during the COVID-19 pandemic. Concerns have been communicated to the OIG by the community, the Board of Supervisors, and some advocacy groups.

The Board of Supervisors directed the OIG to examine how the SSO has been working to protect both inmates and staff at the jail facilities. During this review, it was determined that the SSO was proactive in their response. In coordination with Correctional Health Services (CHS), the SSO conducted risk assessments of the Sacramento County jail facilities.

Based on those assessments, the SSO created site-specific safety protocols to outline COVID-19 guidelines and procedures in order to protect both inmates and staff. These protocols address the following:

- COVID-19 symptom identification
- Inmate management
- Masking requirements
- Personal protective equipment (PPE)
- Isolation/Quarantine process
- Contact tracing
- Potential outbreak procedures
- Patient returns and transfers
- Inmate transportation procedures
- Prevention procedures
- Cleaning practices
- Employee training

In additional to the establishment of COVID-19 safety protocols, the SSO has been regularly reporting COVID-19 statistics related to the jails.

As of April 28, 2021, here are the latest COVID-19 statistics for both the Main Jail (SCMJ) and the Rio Cosumnes Correctional Center (RCCC):

- Total inmate population (Main Jail & RCCC) 3,208
- Total COVID-19 tests since March 2020 15,444
- Total confirmed COVID-19 cases since March 2020 1,788
- Total confirmed COVID-19 cases during intake since March 2020 373
- Total current inmates who are positive for COVID-19 (Main Jail) 4
- Total current inmates who are positive for COVID-19 (RCCC) 2
- Total number of COVID-19 related deaths 0
- Total inmates who have received at least 1 COVID-19 vaccine dose 1,294

The OIG has extensively reviewed these protocols, interviewed jail staff and management, and conducted site visits. Based on this review, the OIG has come to the following conclusions:

- The COVID-19 written safety protocols are thorough and incorporate national best practices
- Jail staff are well trained
- Jail staff follow the COVID-19 safety protocols
- Jail staff are responsive to inmate complaints regarding COVID-19 safety

Though no system is perfect, the SSO has been proactive and diligent in their efforts to respond to the COVID-19 crisis and put procedures in place that increase safety for both inmates and staff. In this particular area, the OIG believes the SSO has been responsive and transparent.

Tracking of COVID-19 Related Misconduct Complaints

During this review, it was discovered that the identification and tracking of COVID-19 specific complaints were problematic. Though these types of complaints are being fully investigated, they were not being flagged properly for tracking purposes. Because of this, it is difficult to identify exactly how many complaints are solely related to COVID-19.

The OIG spoke to the Professional Standards Division about this issue, and PSD staff agreed to start tracking complaints specifically related to COVID-19.

20-17 Recommendation – Tracking of COVID-19 Misconduct Complaints

The SSO should separately identify and track complaints of misconduct that are related specifically to COVID-19.

Status: In Progress

Tracking of COVID-19 Related Inmate Grievances

Within the jails, there is an inmate grievance process that allows inmates to file written grievances related to the conditions and treatment within the jail facilities. Those grievances are reviewed and investigated by jail supervision and a resolution is eventually communicated to the inmate who filed the grievance.

Though not all inmates agree with the outcome, the process seems to be effective. The OIG is in the process of conducting a complete review of the grievance process. There was one area identified for improvement as it relates to grievances and COVID-19.

As part of the OIG inquiry into COVID-19 jail procedures, the OIG requested information on the number of grievances that were filed in 2020 related specifically to COVID-19. At the time of the request, the OIG was informed that the information requested could not be provided because the grievances specifically relating to COVID-19 were not flagged and tracked. After some discussion with the OIG, staff at the jails agreed to start tracking grievances related specifically to COVID-19.

20-18 Recommendation – Tracking of COVID-19 Related Inmate Grievances

The SSO should separately identify and track inmate grievances that are related specifically to COVID-19.

Status: In Progress

2021 Officer Involved Shootings

As of the date of this report, there has been a total of four Officer Involved Shootings involving deputies from the Sacramento County Sheriff's Office. These incidents are still being investigated. After these cases are closed and reviewed by the Sacramento County District Attorney's Office (DA), the OIG will provide summaries and reviews of these incidents in a future OIG report.

Kershawn Geyger – January 15, 2021
Robert Calderon – January 18, 2021
Ali Hudson – January 19, 2021
Diante Jones Jr. – February 23, 2021

2020 Officer Involved Shootings

There were a total of three Officer Involved Shootings involving deputies from the Sacramento County Sheriff's Office during 2020. These incidents are still being investigated and/or reviewed. After the cases are closed and reviewed by the Sacramento County District Attorney's Office (DA), the OIG will provide summaries and reviews of these incidents in a future OIG report.

Devon Slycord – February 24, 2020
Chris Paul Walker – August 22, 2020
Miguel Flores Hernandez – September 5, 2020

Prior Officer Involved Shootings

Past Inspector Generals have reported on prior Officer Involved Shootings. However, there was about an 18-month gap in reporting between the time the last OIG left office and when the current OIG started.

To help fill this reporting gap, the OIG will provide summaries and reviews of the Officer Involved Shootings that were not previously reported and have been fully reviewed by the Sacramento County District Attorney's Office (DA).

As of the date of this report, the DA has completed their review of the following Officer Involved Shootings that occurred prior to 2020.

Ricardo Jaurequi – June 3, 2018

Summary of Facts
On June 3, 2018, at approximately 4 a.m., Joshua Griffin called 911. The dispatcher was unable to hear the caller, and the phone was then disconnected. The dispatcher was unsuccessful in trying to call Griffin back. With the inability to determine the nature of the call or emergency, deputies David Benjamin and Alexander Spencer responded to the address to investigate.

The deputies arrived to the residence approximately 15 minutes after the call was made. As the deputies walked around the perimeter of the residence, the deputies could hear someone "talking angrily" to himself. Deputies identified Griffin standing outside of his house. Griffin communicated that he was having trouble with his phone, which caused him to become disconnected with the 911 dispatcher.

Griffin indicated that his wife and children had moved out of the house, and he had not seen them for a few months. Griffin informed deputies that he believed his wife and children were at a neighbor's house. He indicated that the name of the neighbor was Ricardo Jauregui. Griffin requested that deputies check the welfare of his wife and children at Jauregui's house and ask if the children wanted to visit him. The deputies agreed. Griffin remained in his driveway while deputies proceeded over to Jauregui's home.

As deputies walked up the Jauregui's home, Deputy Spencer heard the sound of a round being chambered into a firearm. Deputy Spencer yelled, Gun! Gun! Gun! and ran to his right onto the front lawn looking for cover. Deputy Benjamin observed Jauregui moving quickly from the side fence on the left of the home into the front yard. Jauregui yelled, "Get the fuck off my property!" and something close to, "Get out of here you crazy person." Deputy Benjamin observed Jauregui holding what he believed to be a handgun in Jauregui's right hand. Deputy Benjamin retreated to the street and then turned around and drew his firearm. Deputy Benjamin then observed Jauregui holding a handgun in his right hand above his waist. Deputy Benjamin believed at that moment that Jauregui was going to shoot him.

Based on this assessment, Deputy Benjamin fired four shots at Jauregui. Deputy Spencer was unable to find cover and drew his firearm. Deputy Spencer observed Jauregui holding a handgun with both hands and was pointing it in Deputy Benjamin's direction. Deputy Spencer fired four shots at Jauregui. After those shots were fired, Jauregui fell to the ground. After Jauregui fell to the ground, Jauregui yelled, "I'm sorry! I'm sorry!" Deputies determined that Jauregui was shot in the right upper arm and immediately requested medical assistance. The Fire Department and paramedics responded to the scene and administered medical treatment. Jauregui was subsequently transported to the hospital for his non life-threatening injury. A Glock Model 27 .40 caliber pistol was recovered about 4 feet from where Jauregui fell with one round in the chamber and 7 rounds in the magazine.

Jauregui told investigators that Griffin's wife and children were never at his home. He stated that Griffin's father told him that his son was "going off" because his wife and children had left. Another neighbor was approached by Griffin previously asking where his wife and children were. The neighbor told Jauregui that he kept a shotgun by the door because of Griffin's behavior. Jauregui described Griffin as "crazy." Jauregui told investigators that prior to the shooting, he heard yelling and screaming outside. Griffin was yelling his name and yelling that his wife and children were at Jauregui's house and he wanted them back. Jauregui was concerned that Griffin might harm him, so he retrieved a Glock handgun for protection. Jauregui rushed out of the house and observed flashlights illuminating the trees. He thought it

was Griffin using his cellphone flashlight. Thinking it was Griffin, Jauregui yelled, "Get the fuck off my property!" Jauregui stated that he might have raised the gun, but he did not recall aiming it. Jauregui observed the deputies' badges and heard, "Put the gun down." The deputies shot Jauregui, and he fell to the ground.

District Attorney Legal Analysis
A peace officer may use deadly force under circumstances where it is reasonably necessary for self-defense or defense of another. California law permits the use of deadly force if the officer actually and reasonably believed he was in imminent danger of death or great bodily injury. (CALCRIM 505, 507, 3470). An officer who uses deadly force must actually believe that force is necessary. The appearance of danger is all that is necessary; actual danger is not. (*People v. Toledo* (1948) 85 Cal.App.2d 577; *People v. Jackson* (1965) 233 Cal.App.2d 639).

Thus, the officer may employ all force reasonably believed necessary. (CALCRIM 3470). The reasonableness of a particular use of force must be judged from the perspective of a reasonable officer on the scene, rather than with 20/20 hindsight. The calculus of reasonableness must embody allowance for the fact that police officers are often forced to make split-second judgments – in cases that are tense, uncertain, and rapidly evolving – about the amount of force that is necessary in a particular situation. (*Graham v. Connor* (1989) 490 U.S. 386).

In this case, deputies Spencer and Benjamin responded to Jauregui's residence based on Griffin's request to check on his family. As they walked up the driveway, the deputies were confronted by Jauregui chambering a round in his gun, demanding that they get off of his property, and running towards them on a dark street.

While the deputies were retreating from Jauregui, they observed Jauregui holding a gun in a position consistent with shooting them. The deputies did not know that Jauregui's intent was to frighten Griffin. Although inadvertent, Jauregui displayed deadly force to the unsuspecting deputies. Given the totality of Jauregui's words and conduct, it was reasonable for Deputies Spencer and Benjamin to believe they were in imminent danger of death or great bodily harm.

District Attorney Conclusion
Deputies Spencer and Benjamin were justified in shooting Jauregui in self-defense and in defense of each other. Their conduct under these circumstances was lawful. Accordingly, we will not take further action in this matter.

OIG Review
The OIG reviewed the circumstances surrounding this case to determine if there were any issues or discrepancies related to department policies, operations, tactics, or training. Based on this review, the OIG did not find the need to issue any recommendations stemming from this Officer Involved Shooting.

Travis York – December 15, 2018

Summary of Facts
On December 15, 2018, Travis York, Dale Dare, and Donald Horstein stole a television and sound bar from a Walmart in Elk Grove. The Elk Grove police department located the suspects' vehicle at a gas station. All three suspects were in the vehicle along with the stolen property. Dare and Horstein were immediately detained without incident. York, who was sitting in the back seat, refused to follow the officers' directions. York then pulled out a handgun, held it to his head, and threatened to shoot himself. Officers immediately backed off. York then climbed

into the driver's seat and fled at a high rate of speed. Officers chased the vehicle but eventually lost sight of it. Officers located the vehicle parked at a nearby residence. As officers approached the house, they observed York and a female walk out of the residence. York dropped his backpack, ran into the backyard, and jumped over a fence and fled on foot. Dare and Horstein identified the outstanding suspect as Travis York. A records check indicated that York had an outstanding arrest warrant as a parolee-at-large.

Shortly afterwards, Elk Grove Police received a report of an attempted carjacking. It was discovered that York attempted to carjack a citizen at gunpoint a short distance from where York was last seen. York successfully carjacked a second citizen and fled the area in her Toyota 4Runner. Elk Grove police department detectives obtained an arrest warrant and contacted the Sacramento County Sheriff's Office for assistance in arresting York. Sheriff Detectives Lemus and Bell attended a briefing and were told that York had prior military experience and training.

On December 17th, detectives were conducting surveillance when they observed a white female enter the driver's side of an Isuzu Rodeo parked in the parking lot of a nearby motel. Detective Lemus could see that a white male was in the passenger seat. Lemus believed there was a high probability that it was York in the vehicle, but he could not make a positive identification. Lemus followed the vehicle in an unmarked car. Detective Bell was in a fully marked Sheriff's vehicle and followed behind them.

As they continued to follow the vehicle, Detective Lemus observed the white male sitting low in the passenger seat, as if to conceal himself. He then observed the male reach into the back seat to grab a bag. Detective Lemus believed at the time that the white male might have been arming himself. The Isuzu drove into a parking lot where Detective Bell was able to positively identify that the white male passenger was Travis York.

The Isuzu then started to park in a parking stall. As the vehicle came to a stop, York stepped out of the vehicle and began walking toward Detective Lemus. Detective Lemus believed York had a handgun in his hands and exited his unmarked vehicle with his rifle and began shouting directions at York. Detective Lemans was wearing a gun belt and black vest with a badge and the word "Sheriff" clearly marked on the front and back.

York failed to obey the commands. Deputy Lemus noticed that York's hands were in the area of his waistband. York climbed back into the Isuzu. Detective Lemus did not know whether the female driver was with York willingly. He believed York was not going to surrender and was concerned that York was going to shoot at him or his fellow responding officers to avoid apprehension.

Detective Bell exited his marked patrol vehicle wearing the same identifying markings as Detective Lemus. He observed that York was not following the commands of Detective Lemus. As Detective Bell was placing himself in a position that would pose the least risk to innocent bystanders, he observed York move his hands from the area of his chest to the area of his waistband, look directly at Detective Bell, and walk briskly back to the Isuzu passenger door. The passenger door opened, and Detective Bell saw York's hands in the area of his waistband. Detective Bell saw a black object that he believed was a gun.

Detective Bell was in fear for his life, the lives of his partner, and the lives of the civilian shoppers located nearby. Both Detectives Lemus and Bell fired their rifles at York. Detective Lemus fired six shots, and Detective Bell fired 10 shots. York fell to the ground. Responding

officers administered first aid, but York died at the scene. A loaded black semi-automatic pistol was found underneath York's body. A full box of 9mm ammunition and 28 grams of methamphetamine were found in York's jacket pockets. An autopsy confirmed the presence of methamphetamine in York's system.

The driver and owner of the Isuzu told investigators that she had known York for about a week. She stated that she had seen York with a knife and a gun. As they were driving, York told her that he suspected police were following them. She thought York was being paranoid. York noticed that the vehicle Detective Lemus was driving was following them. She indicated that as she began to park in a parking stall, York jumped out of the vehicle before it came to a complete stop. York then came back and yelled, "Go! Go! Go! Get out of here!" She could see that the officers were law enforcement based on how they were dressed. She refused to drive, and she heard the officers yelling for York to put his hands up and then heard a bunch of gunshots.

A witness at the scene observed an officer pointing a rifle and then observed a tall white man wearing a jacket in the area where the rifle was being pointed. She described that the tall white man reached inside his jacket as if he was reaching for a weapon. She observed the officer approaching and yelling for the subject to stop. She then observed the subject running back to his car. As she began to run away, she heard "a lot of gunshots." The in-car camera from Detective Bell's vehicle shows Detective Bell exiting his vehicle, and a voice can be heard yelling, "Show me your fuckin' hands! Let me see your hands, now!" About 6 seconds later, there are the sounds of several shots, a pause, and then a second flurry of several shots.

District Attorney Legal Analysis
A peace officer who has reasonable cause to believe a person has committed a public offense or is a danger to others may use reasonable force to detain or arrest the person, to prevent the person's escape, or to overcome the person's resistance. (California Penal Code section 835a; CALCRIM 2670).

An officer who detains or arrests a person does not need to retreat or stop his or her efforts if the person resists or threatens resistance. Moreover, using reasonable force does not make the officer an aggressor or cause him or her to lose the right to self-defense. (California Penal Code section 835a). The person being detained or arrested has a duty to permit himself or herself to be detained, and the person must refrain from using force or any weapon to resist arrest. (*People v. Allen* (1980) 109 Cal.App.3d 981, 985; California Penal Code section 835a; CALCRIM 2670, 2671, 2672).

In the present matter, Detective Lemus and Detective Bell had been briefed that York and his two crime partners had stolen a television and a sound bar from Wal-Mart. When officers located and detained their vehicle with the stolen property, York put a gun to his own head, threatened to shoot himself, jumped into the driver's seat, and drove away at a high rate of speed, jumped a fence and eluded officers. York then tried to carjack two separate victims at gunpoint and was successful on his second attempt.

Detective Lemus and Detective Bell clearly had reasonable cause to detain York for these public offenses. The detectives ordered York to stop and to put his hands in the air, but York refused. York had a duty to submit himself to Detective Bell and Detective Lemus' custody, just as he had a duty to submit to the custody of Elk Grove Police on the two occasions following the theft from Wal-Mart. He failed to do so. Instead, York ignored the detective's

commands, ran back towards the Isuzu, ordered the driver to drive away, and appeared to be grabbing for his semi-automatic pistol.

A peace officer may use deadly force under circumstances where it is reasonably necessary for self-defense or defense of another. California law permits the use of deadly force if the officer actually and reasonably believed he or she was in imminent danger of death or great bodily injury (CALCRIM 505, 507, 3470). An officer who uses deadly force must actually believe that force is necessary. The appearance of danger is all that is necessary; actual danger is not (*People v. Toledo* (1948) 85 Cal.App.2d 577; *People v. Jackson* (1965) 233 Cal.App.2d 639). Thus, the officer may employ all force reasonably believed necessary (CALCRIM 3470). The reasonableness of a particular use of force must be judged from the perspective of a reasonable officer on the scene, rather than with 20/20 hindsight.

The calculus of reasonableness must embody allowance for the fact that police officers are often forced to make split-second judgments – in circumstances that are tense, uncertain, and rapidly evolving – about the amount of force that is necessary in a particular situation (*Graham v. Connor* (1989) 490 U.S. 386).

1. *This incident occurred prior to California Assembly Bill 392's amendments to Penal Code sections 196 and 835a. Therefore, this incident is analyzed under the law as it existed at the time of the events.*

Here, Detective Lemus and Detective Bell were reasonable in their belief that York posed an imminent danger of death or great bodily injury to themselves, each other, and the public who were in the immediate vicinity of the parking lot. The detectives had been briefed on the circumstances of York's prior actions during the last two days, including the lengths he would go to avoid capture. They knew York was armed, and they were aware that he pulled a firearm and pointed it at his own head and threatened to shoot in order to escape from the officers following the theft in Elk Grove.

They were aware that he had then driven at a high rate of speed to avoid officers, placing others on the roadway at risk of injury. They were further aware that he then attempted a carjacking at gunpoint to obtain a vehicle to avoid capture and that he then committed a second carjacking at gunpoint of a separate victim.

When the detectives were following York in the white Isuzu on December 17, they did not know if the woman driving the Isuzu was with York willingly. They did not know if she was a hostage and was in danger when York ran back to the Isuzu during the encounter with the detectives, or if she was a willing participant who could provide York with his means of escape.

The detectives were further aware of the proximity of numerous civilians in the immediate vicinity coming to or from their cars as they shopped in the supermarket. They were afraid that any of them were potentially in danger from being struck by gunfire if York decided to start firing at the detectives. They were further aware that York might try to take one of the civilians or their vehicles to make his escape.

As the detectives confronted York in the parking lot, they were wearing distinctive vests identifying themselves as law enforcement. Detective Bell was standing outside a marked patrol unit, both officers were carrying rifles, and they were giving commands to York for him to raise his hands and surrender. Not only did York refuse to comply, he attempted to re-enter

the Isuzu and, as also observed by a civilian witness, appeared to be reaching in his jacket for a gun. Detective Bell observed a black object that he believed to be a gun. Given all of these circumstances, the detectives' belief that York posed an imminent danger of death or great bodily injury to others was reasonable.

District Attorney Conclusion
Based on the circumstances of this incident, Detectives Lemus and Bell were justified in shooting York to defend themselves and others. York posed a significant threat of death or serious physical harm to the detectives and others. Accordingly, we will take no further action in this matter.

OIG Review
The OIG reviewed the circumstances surrounding this case to determine if there were any issues or discrepancies related to department policies, operations, tactics, or training. Based on this review, the OIG did not find the need to issue any recommendations stemming from this Officer Involved Shooting.

2021 In-Custody Deaths

As of the date of this report, there has been a total of four In-Custody Deaths in 2021. These incidents are still being investigated. After these cases are closed and reviewed by the Sacramento County District Attorney's Office (DA), the OIG will provide summaries and reviews of those incidents in a future OIG report.

Untwan Smith – January 26, 2021
William Stevens – February 16, 2021
Deyyj Watts – February 26, 2021
Jadmon Barrett – April 2, 2021

2020 In-Custody Deaths

The following In-Custody Deaths occurred in 2020. These cases are still open and under investigation. Once these cases are closed and reviewed by the Sacramento County District Attorney's Office (DA), the OIG will provide summaries and reviews of those incidents in a future OIG report.

Antonio Thomas – January 21, 2020
Gary Hamlin – January 27, 2020
Travis Welde – August 4, 2020
Herman Johnson – August 11, 2020
Michael Bazley – November 9, 2020
Gonzalo Garcia – November 23, 2020

Prior In-Custody Deaths

Past Inspector Generals have reported on In-Custody Deaths. However, there was about an 18-month gap in reporting between the time the last OIG left office and when the current OIG started. To help fill this reporting gap, the OIG will provide summaries and reviews of the In-Custody Deaths that were not previously reported and have been fully reviewed by the Sacramento County District Attorney's Office (DA). As of the date of this report, the DA has completed their review of the following In-Custody Deaths that occurred prior to 2020.

Kenton Ballard – February 28, 2018

Summary of Facts
On February 7, 2018, Kenton Ballard was booked into the Sacramento County Main Jail (SCMJ) for a probation violation and possession of drug paraphernalia. During intake, he denied that he had any issues with chest pain, shortness of breath, difficulty breathing, recent injuries, or serious medical conditions. On February 23, 2018, Ballard was transferred to the Rio Cosumnes Correctional Center (RCCC).

Sacramento County Sheriff's Deputy Brown was working as a transportation officer at RCCC on the morning of February, 28, 2018. He and other deputies were responsible for transporting inmates from RCCC to SCMJ for court appearances. Ballard was one of the multiple inmates scheduled for transport. Deputy Brown first contacted Ballard at the RCCC holding tank prior to transport to SCMJ. Ballard's appearance and demeanor appeared normal, and he did not report any medical difficulties to Deputy Brown. Ballard was transported to SCMJ and placed in a holding tank without incident.

At approximately 6:57a.m., Deputy Rowe was notified of a "man down" in a transport cell. Deputy Rowe and a nurse responded and found Ballard lying on the floor. Deputy Rowe saw no visible signs of trauma to Ballard's face or body and observed no blood on his person or immediate vicinity.

Ballard appeared confused, and quietly mumbled that his stomach hurt. Deputy Rowe and the nurse removed Ballard from the cell and assisted him in sitting up against the wall. Deputy Rowe asked Ballard what was wrong, and Ballard indicated he could not keep anything down. The nurse and additional medical staff assessed Ballard's vitals. Deputy Rowe and the nurse placed Ballard in a wheelchair and took him to the nurse's station. Ballard appeared to be more coherent and requested water. Ballard drank the water and appeared more alert.

Ballard told medical staff he had been experiencing stomach and neck pain and diarrhea for about two weeks. An examination determined Ballard had a weak pulse and his blood pressure was unobtainable. A test for occult blood during the rectal exam was strongly positive. A Code 2 ambulance was requested for Ballard at approximately 7:20 a.m. Shortly afterwards the request was upgraded to Code 3. At 7:35 a.m., Deputy Pearson was assigned to accompany Ballard in the ambulance from the jail to Sutter Medical Center. Paramedics arrived at the nurse's station inside the jail at approximately 7:41 a.m. Paramedics provided medical attention and took him on a gurney to an ambulance. Ballard was conscious and speaking with paramedics inside the ambulance.

Ballard was transferred to the Sutter Medical Center Emergency Room at approximately 8:00 a.m. At that time, he was still conscious and responsive. Ballard stated that he was experiencing pain all over his body, especially his stomach and back. Deputy Pearson observed Ballard writhing around in his hospital bed. According to Deputy Pearson, once the medical staff gave him pain medication, Ballard fell asleep. Meanwhile, Deputy Pearson observed the medical staff performing medical tests on Ballard.

Ballard began yelling for help at approximately 10:18 a.m. According to Deputy Pearson, the physician had difficulty treating Ballard due to his writhing and yelling, and Ballard was given more pain medication. As the doctor prepared to draw additional blood from him, Ballard's breathing slowed and stopped. The doctor and staff performed CPR and intubated Ballard. A short time later, Ballard was stabilized and medical care and testing continued. Once test results

came back, medical staff told Deputy Pearson at approximately 11:05 a.m. that Ballard's chance of survival was low. Medical staff continued treatment. At approximately 12:03 p.m., the Sheriff's Office released Ballard from custody. Ballard remained at the hospital, and the Sheriff's deputies had no further contact with him. Ballard died at approximately 1:48 p.m.

Following his death, multiple inmates were interviewed. Inmates who observed Ballard on the bus from RCCC to SCMJ indicated generally that Ballard appeared sick and was breathing abnormally. Inmates who observed Ballard in the holding tank as SCMJ indicated that Ballard did not appear well and was observed groaning on the floor. An inmate pressed the emergency button and deputies and a nurse responded. Ballard was taken away on a stretcher.

The report of the Sacramento County Coroner indicated the cause of Ballard's death was disseminated cryptococcosis. There was no evidence of trauma. According to a memorandum by Dr. Grant G. Nugent, MD, Medical Director of Correctional Health Services, disseminated cryptococcosis is a disease caused by a fungus. The Sacramento County District Attorney's Office Laboratory of Forensic Services examined a sample of Ballard's femoral blood. The laboratory determined Ballard's blood contained lidocaine. The Coroner's report indicated the presence of lidocaine was "most likely related to the resuscitation procedure."

District Attorney Conclusion
Ballard died from a disease and no evidence of criminal misconduct is presented or suggested in any of the supporting reports. The District Attorney's Office will take no further action in this matter.

OIG Review
The OIG did not find any evidence of employee misconduct, negligence, or policy violations by SSO staff. The review did not reveal any issues or discrepancies related to department policies, operations, tactics, or training.

Defei Chen – April 4, 2018

Summary of Facts
On April 4, 2018, Chen was sharing a cell with another inmate. Sacramento County Sheriff's Deputies Conley and Douglas were on duty in Chen's housing unit. At approximately 2:38 a.m., Deputy Douglas conducted cell checks and discovered nothing unusual in Chen's cell. At approximately 3:39 a.m., Deputy Conley conducted cell checks and discovered Chen hanging with a torn towel around his neck attached to the top of the cell door.

Deputy Conley radioed for assistance and opened the cell door. Chen fell limp to the floor and the piece of towel that was around Chen's neck detached from the cell door. Deputy Vasquez responded, and the deputies were unable to remove the makeshift rope from around Chen's neck. Chen did not appear to be breathing, and Deputy Vasquez requested medical assistance and an ambulance. Deputy Conley was unsure if he felt a pulse and requested a breathing mask from the control room.

At approximately 3:40 a.m., Deputy Clark arrived with a cut-down tool and cut the tie from Chen's neck. The makeshift rope was a length of torn white jail-issued towel. Conley began to perform chest compressions. At approximately 3:42 a.m., jail medical staff arrived and placed a breathing mask and Automated External Defibrillator on Chen as deputies continued chest compressions. At approximately 3:49 a.m., Sacramento County Fire Medics arrived and continued medical treatment. Chen was pronounced deceased at approximately 3:52 a.m.

Deputy Conley noted that Chen's cellmate remained lying flat on the lower bunk of the cell throughout the incident. At approximately 3:57 a.m., Deputy Craft spoke with Chen's cellmate, who stated that he was asleep during this incident until being awakened by one of the deputies asking him what occurred.

Surveillance video from the Main Jail was reviewed. The events as shown on the video occur in the same manner as described in the reports. The Sacramento County Coroner's Office classified the manner of Chen's death as a suicide. Pathologist Keng-Chih Su, M.D., conducted an autopsy and concluded that the cause of Chen's death was hanging.

District Attorney Conclusion
No evidence of criminal misconduct is presented or suggested in any of the supporting reports. The District Attorney's Office will not take any further action in this matter.

OIG Review
The OIG did not find any evidence of employee misconduct, negligence, or policy violations by SSO staff. The review did not reveal any issues or discrepancies related to department policies, operations, tactics, or training.

Juan Carlos Heras-Castro – April 24, 2018

Summary of Facts
On February 22, 2018, Heras-Castro was booked into custody at the Main Jail. On the date of the incident, Heras-Castro was the sole occupant of his assigned cell. Deputy Lukes was on duty and conducted his hourly cell check and pill call with Registered Nurse (RN) Scott Lovell. At approximately 10:45 p.m., Deputy Lukes and Nurse Lovell knocked on Heras-Castro's door to administer his pills. Deputy Lukes noticed Heras-Castro was hunched over on his knees with a noose around his neck tied to his cell light.

Deputy Lukes immediately radioed for assistance and entered the cell to render aid. Deputy Pantoja also entered the cell and helped lift Heras-Castro to his bunk as the noose was removed. The noose was made from a jail-issued towel, which was ripped into multiple strips and tied together. No pulse was found, and Detective Pantoja began administering chest compressions while Deputy Grinder responded with an Automated External Defibrillator (AED). RN Lovell applied the AED and chest compressions were continued.

Sacramento Fire Department personnel arrived at approximately 10:53 p.m. and pronounced Heras-Castro deceased. An inmate in a neighboring cell was interviewed. The inmate stated he was communicating with Heras-Castro by knocking on the wall back and forth during the last cell check the hour prior.

Surveillance video from the Main Jail was reviewed. A check of inmate Heras-Castro's cell occurred at the following times: At 6:40 p.m., a deputy walked by inmate Heras-Castro's cell and looked inside. At 8:03 p.m., Deputy Lukes walked by inmate Heras-Castro's cell and looked inside. At 8:46 p.m., a deputy walked by inmate Heras-Castro's cell and looked inside.

At 8:54 p.m., an inmate walked up to inmate Heras-Castro and appeared to speak to him for a couple of minutes. At 9:57 p.m., another check was performed by Deputy Lukes. At 10:23 p.m., a cleaning crew entered the pod. A deputy supervising them appeared to have a conversation with an inmate in a neighboring cell. There is no indication as to whether he

checked on Heras-Castro. At 10:45 p.m., Deputy Lukes approached the cell for pill call and looked inside. He discovered Heras-Castro hanged himself.

The Sacramento County Coroner's Office classified the manner of Heras-Castro's death as a suicide. Pathologist Keng-Chih Su, M.D., conducted an autopsy and concluded that the cause of death was hanging.

District Attorney Conclusion
No evidence of criminal misconduct is presented or suggested in any of the supporting reports. The District Attorney's Office will not take any further action in this matter.

OIG Review
The OIG did not find any evidence of employee misconduct, negligence, or policy violations by SSO staff. The review did not reveal any issues or discrepancies related to department policies, operations, tactics, or training.

Donald Bell – June 2, 2018

Summary of Facts
Bell was booked into the Sacramento County Main Jail (SCMJ) on January 5, 2018. A screening nurse determined that Bell was fit for incarceration. At the time of his booking, Bell was 71 years old. Over the next four months, Bell's medical condition required him to be hospitalized on multiple occasions. His conditions included open wounds to his legs, dementia, type 2 diabetes, ulcers, hypertension and cellulitis. Bell also received dialysis.

On May 31, 2018, Bell was transported to the UC Davis Medical Center due to open sores on his legs and low blood pressure. Hospital staff determined that Bell was not expected to live longer than 24 hours due to septic shock and complications of pneumonia. Hospital staff also noted that Bell had major swelling and necrosis to his lower legs. The hospital staff informed Sacramento County Sheriff's Office (SSO) personnel that they had done all they could to treat Bell medically. The hospital administered medication to keep Bell comfortable. Bell remained unresponsive. On June 1, 2018, the Sacramento Superior Court released Bell on his own recognizance in his pending criminal case (Superior Court No. 18FE000446) due to his grave illness. SSO staff notified the hospital of Bell's release. Bell died on June 2, 2018 at approximately 1:33 p.m.

The Sacramento County Coroner's Office did not perform an autopsy. The Death Certificate was signed by UC Davis Medical Center Dr. Bradley Tokeshi. The immediate cause of death was listed as multi-organ failure. Other conditions noted as leading to his cause of death were septic shock, streptococcus pyogenes bacteremia, and bilateral lower extremities cellulitis and abscess-unknown etiology. Other significant conditions noted as contributing to death were right lower lobe pneumonia, atrial fibrillation, and pulmonary embolism.

District Attorney Conclusion
No evidence of criminal misconduct is presented or suggested in any of the supporting reports. The District Attorney's Office will not take any further action in this matter.

OIG Review
The OIG did not find any evidence of employee misconduct, negligence, or policy violations by SSO staff. The review did not reveal any issues or discrepancies related to department policies, operations, tactics, or training.

Rakeisha Holdman – March 28, 2019

On March 28, 2019 at approximately 8 a.m., Holdman attempted to exchange a $100 bill at Brookfields restaurant in Sacramento. An employee suspected the bill was counterfeit and returned it to Holdman. Holdman left and approached Clay Gary, from whom she had received the $100 bill. When she entered Gary's vehicle, a physical altercation ensued. Witnesses from the restaurant saw Gary striking Holdman in the chest and face while the two of them were seated in his vehicle.

Holdman escaped from Gary's care and ran topless from the vehicle. Holdman then ran to Brookfields while Gary gave chase. She made it inside, and a witness stopped Gary from entering. Holdman ran out the back door and went to her husband, Ernest Holdman's car, which was parked near the rear of the restaurant. Gary began yelling at Ernest about the money and in response, Ernest brandished a knife. Gary retreated until police arrived.

At approximately 8:11 a.m., Deputy Galovich pulled into the parking lot of Brookfields and was waved down by a witness who had called 911 due to the dispute. Deputy Galovich had not been dispatched to the call. He stayed and requested an additional unit respond. Deputy Galovich contacted Gary in the parking lot. As Gary explained his dispute with Holdman, Ernest approached and started arguing with Gary.

Deputy Galovich then saw Holdman leaning against the back of a tan Cadillac, and he asked her to come over to him. She yelled that she could not walk. Deputy Galovich then instructed her to sit down. Additional deputies arrived to assist. Deputies Galovich and Griggs approached Holdman and explained to her that Gary thought she had taken his money. Holdman replied, "I can't talk if I can't breathe." Deputy Galovich observed that Holdman was breathing heavily. He asked her if she wanted the fire department to check on her and she said no. Another witness approached Holdman and handed her a cup of milk to drink. Holdman drank some milk and was no longer breathing heavily. She told the witness that she suffered from asthma and asked the witness to pat her on the back.

Deputy Griggs discovered Holdman had an outstanding warrant out of Solano County. Deputy Galovich again asked her about the money at which point she resumed breathing heavily and said she couldn't talk because she needed to catch her breath. Deputy Galovich again asked Holdman if she wanted the fire department to respond and again she declined.

Ernest gave Deputy Galovich consent to search his car. The search revealed suspected narcotics and smoking paraphernalia. Deputy Galovich asked who the drugs belonged to. Holdman, now breathing normally, said they belonged to her. Deputy Galovich again tried to ask her about the missing money, but she resumed breathing heavily. He again asked her if she needed medical attention, and she said, "no."

Based upon Holdman's breathing issues, her outstanding arrest warrant, and the suspected narcotics, Deputy Galovich decided to detain her and request medical attention for her. He again asked her if she wanted medical attention, but she declined. Deputy Galovich told her that she was being detained, and he handcuffed her in front of her stomach. Holdman was sitting upright, but she was still having difficulty breathing.

Deputy Galovich requested the fire department respond at approximately 8:32 a.m. Holdman told Deputy Galovich that she needed to lean back. He had her lean against the rear bumper of the Cadillac, and she continued with deep breaths. Deputy Galovich stayed with Holdman until

the Sacramento Metro Fire Department arrived. During this time, Deputy Galovich noticed that Holdman was awake, coherent, and looking around. He observed her breaths to be less deep and more normal. Deputy Galovich informed fire personnel that when he would ask Holdman questions, she appeared to breathe deeper, but when she was not being questioned, her breathing would return to normal.

Fire personnel began to talk to Holdman, who was still in the seated position and learning against the vehicle. Holdman was mumbling. Her pupils rolled upwards and she fell to her right side. Fire personnel could not locate a pulse, and a clear, brownish liquid ran out of her nose. Deputy Galovich immediately uncuffed her. Fire personnel transported her to Mercy San Juan Hospital, where her pulse returned. After Holdman arrived at the hospital, she was released from custody. Holdman remained at the hospital on a ventilator for two days before her death.

The substance found in the Holdmans' vehicle was booked into evidence and sent to the Sacramento County District Attorney Crime Lab. Lab results confirmed the substances as 0.4 grams of methamphetamine and 1.3 grams of marijuana.

The Sacramento County Coroner's Office classified the manner of Holdman's death as likely a combination of heart issues and cocaine toxicity. Pathologist Keng-Chih Su, M.D., conducted an autopsy and concluded that the cause of Holdman's death was cocaine intoxication. Contributing conditions, but not related to the immediate cause of death, were blunt force injuries to the head and dilated cardiomyopathy. A toxicology report indicated the presence of cocaine and THC in Holdman's system.

In Earnest Holdman's later interview with investigators, he stated that his wife was in the passenger seat of their car when Deputy Galovich contacted them. He said that Deputy Galovich instructed Holdman to get out of the car and that Ernest had to take her hand to help her out. He said that Holdman was "manhandled" by Deputy Galovich "as if she was able to stand up and run." However, no other witnesses support this account. Gary was interviewed and stated he did not see a struggle between Deputy Galovich and Holdman. Another witness, a Brooksfield employee who saw the initial struggle between Gary and Holdman, stated Deputy Galovich had nothing to do with the medical issues Holdman experienced. He related that he saw no fight or struggle between Deputy Galovich and Holdman.

District Attorney Conclusion
Based on the evidence, there was no criminal misconduct on the part of law enforcement. As such, the District Attorney's Office will take no further action in this matter.

OIG Review
The OIG did not find any evidence of employee misconduct, negligence, or policy violations by SSO staff. The review did not reveal any issues or discrepancies related to department policies, operations, tactics, or training.

Recruit Death

On Wednesday, June 19, 2019, a Sacramento County Sheriff's Academy Recruit collapsed immediately after participating in a Sustained Confrontation Learning Activity, which is a Peace Officer Standards and Training (POST) requirement for all Peace Officer recruits to complete in order to obtain Peace Officer certification. This learning activity is a high-stress and high-exertion physical activity exposing the recruit to a simulated foot pursuit, ground fighting, down officer rescue, and suspect search and arrest.

On the day of the training exercise, the recruit conducted the approximate 10 minute exercise. At the conclusion of the learning activity, the recruit was showing signs of medical distress. He collapsed in exhaustion and was showing signs of confusion. Academy staff began basic first aid, but the recruit eventually became unconscious and unresponsive. The training staff then contacted Fire to respond and treat the recruit. Though the timeline is not completely clear, it appears Fire arrived on the scene within 10-20 minutes after the recruit started showing signs of distress. The recruit was transported via ambulance to Mercy San Juan Hospital for additional medical treatment.

While being treated at the emergency room, the recruit's condition continued to deteriorate. The recruit was showing signs of heat exhaustion and was having issues with his heart and other organs. The treating physicians communicated to academy staff that they were perplexed as to why the recruit was showing such severe reactions to a relatively short physical activity considering the recruit's excellent physical shape. Even with all of the medical treatment he was receiving, the recruit did not recover and passed away on Friday, June 21, 2019.

After his death, the Sacramento Sheriff's Office (SSO) received a number of anonymous complaints alleging that the academy training staff were negligent in how they responded to the medical emergency. The anonymous complaints appear to have been generated from within the agency. Subsequently, the SSO opened an Internal Affairs investigation to investigate the allegations of negligence. At the conclusion of that investigation, the SSO determined that the complaints were unfounded.

After being hired in February 2020, the OIG and Board of Supervisors received more anonymous complaints asking that the new OIG investigate the circumstances surrounding the recruit death. These were the same anonymous complaints received earlier by the SSO, and the complaints were alleging that the Internal Affairs investigation was not conducted properly.

The OIG reviewed the Internal Affairs investigation surrounding the recruit's death and found that the Internal Affairs investigation was conducted fairly, thoroughly, and accurately. The OIG concurred with the findings that there was no misconduct on the part of academy staff, and that the actions of the academy staff did not contribute to the recruit's death. However, the OIG did discover some operational issues that should be addressed by the SSO. The OIG does not believe these recommended changes would have produced a different outcome in the case of the recruit's death, but the OIG does believe these changes should be implemented to ensure the department is incorporating best practices as it relates to training policies and guidelines.

Training Safety Protocols

The SSO should develop a more thorough training safety protocol as it relates to conducting physical training during high temperatures. The policy should provide more direction to instructors as it relates to hydration and when training should be modified. The policy should require instructors to document when training is modified and why. It is the opinion of the OIG that the current department training safety policy 1.3.2 is too vague and does not provide academy instructors adequate direction.

20-19 Recommendation – Tracking of COVID-19 Training Safety Protocols

The SSO should revise training safety policy 1.3.2 to provide more clarity and documentation requirements for operating physical training in high temperatures.

Status: Pending

Safety Officer

SSO training policies do provide for having a Safety Officer assigned for certain types of training activities. Within this investigation, it is not clear if a Safety Officer was specifically assigned for this training event, and there are no written records to determine if a Safety Officer was present.

20-20 Recommendation – Safety Officer

The SSO should ensure a Safety Officer is designated whenever physical training is conducted, and a Safety Officer log should be maintained to document that this was completed.

Status: Pending

2021 OIG Focus Areas

The OIG is working on a number of audits and reviews that will be fully summarized in the OIG's 2021 Annual Report. The following list includes some of the major focus areas that will be reported on in 2021.

Review of Inmate Grievance Procedures

The OIG is in the process of auditing the Inmate Grievance process.

Review of Mental Health Screening and Care of Inmates

The OIG is in the process of reviewing how inmates are screened for mental illness during the booking process, and the jail procedures for how those inmates are monitored and treated while in custody.

Use of Force Trends

The OIG is examining department-wide use of force applications in order to identify any trends that might indicate systemic issues with the application of force by SSO employees.

Pursuit Policy

The OIG is in the process of examining the Sacramento County Sheriff's Office Pursuit Policy.

Litigation Review

The OIG is currently reviewing the risk management process the SSO and County uses to analyze successful litigation against the SSO in order to identify lessons learned and develop recommendations to address any changes that are needed to department policies, practices, or training.

Implementation of the Community Review Commission (CRC)

At the request of the Board of Supervisors, The OIG will be assisting the County Executive and County Counsel with the implementation of the new Community Review Commission (CRC).

Appendix A – Complete List of Recommendations

20-1 Recommendation – Informal Complaint Resolution

The SSO should develop a tracking and documentation system for all minor citizen complaints currently being resolved informally at the supervisory level.

Status: Pending

20-2 Recommendation – Internal Affairs Complaint Tracking

The Internal Affairs Bureau should log and document all citizen complaints regardless of their perceived validity.

Status: Completed

20-3 Recommendation – Initial Complaint Documentation

The SSO should revise policy 3-01 Section III (C) to mandate that a supervisor or watch commander document a citizen complaint and forward that complaint to the Professional Services Division for review and classification.

Status: Pending

20-4 Recommendation – Receipt of Complaints – Documentation

The SSO should require the responsible investigative staff (either IA or the Division) place a copy of the letter or email in the investigative file, or if it was done via phone call, the investigative staff should make note of that contact in the file.

Status: Pending

20-5 Recommendation – Communication with Complainants – Status Updates

The SSO should require the responsible investigative staff provide a written status update to the complainant when investigations go beyond the normal timelines and place a copy of the notification in the investigative file.

Status: Pending

20-6 Recommendation – Complaints Related to Medical Treatment of Inmates

The SSO should work with CHS to develop a better tracking and documentation system for complaints referred to CHS by SSO related to the medical treatment and care of inmates.

Status: Pending

20-7 Recommendation – Misconduct Investigation Training

All supervisors and commanders responsible for conducting citizen complaint and internal misconduct investigations should receive annual refresher training on misconduct investigation procedures.

Status: Pending

20-8 Recommendation – Complaint Dispositions

The SSO should examine their current practices for closing cases and assigning dispositions and revise that process to make it more consistent with national best practices.

Status: Pending

20-9 Recommendation – Body Worn Cameras

The SSO should implement a Body Worn Camera program.

Status: In Progress

20-10 Recommendation – Providing Information to the Public

The SSO should provide their own annual public report outlining their citizen complaint and investigation data.

Status: Pending

20-11 Recommendation – SSO Online Complaint/Commendation Form

The link for the SSO online complaint/commendation form should be placed clearly on the Sheriff's Office main web page.

Status: Pending

20-12 Recommendation – OIG Notification of Serious Incidents and Allegations

The SSO should immediately notify the OIG when there is an in-custody death, force resulting in serious injury, any allegations of criminal misconduct, and any high-profile allegation of misconduct that will likely draw the attention of the community and the media.

Status: Pending

20-13 Recommendation – Tracking Use of Force Data

The SSO should fully utilize the "Blue Team" software to track, analyze, and report on use of force incidents.

Status: In progress

20-14 Recommendation – Documenting Use of Force Board Reviews

The SSO should ensure all Use of Force Board reviews are documented in writing.

Status: Pending

20-15 Recommendation – Use of Force Analysis

The SSO should conduct a full analysis of the agency's use of force and provide a written report to the Board of Supervisors and public at least annually.

Status: Pending

20-16 Recommendation – Carotid Neck Restraint

The SSO should eliminate the use of the Carotid Neck Restraint.

Status: Completed

20-17 Recommendation – Tracking of COVID-19 Misconduct Complaints

The SSO should separately identify and track complaints of misconduct that are related specifically to COVID-19.

Status: In Progress

20-18 Recommendation – Tracking of COVID-19 Related Inmate Grievances

The SSO should separately identify and track inmate grievances that are related specifically to COVID-19.

Status: In Progress

20-19 Recommendation – Tracking of COVID-19 Training Safety Protocols

The SSO should revise training safety policy 1.3.2 to provide more clarity and documentation requirements for operating physical training in high temperatures.

Status: Pending

20-20 Recommendation – Safety Officer

The SSO should ensure a Safety Officer is designated whenever physical training is conducted, and a Safety Officer log should be maintained to document that this was completed.

Status: Pending