SACRAMENTO COUNTY

Office of Inspector General

August 1,2022 – August 31, 2023
Year-End Report

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Inspector General

Contents

Executive Summary

The Office of Inspector General (OIG) is an independent monitor who provides oversight of investigations of community 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 of relative findings and recommendations. In addition to the community 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 in line with national best practices.

This report is being provided in written form as a first draft due to time constraints regarding delivery of this report. Typically, the OIG would give a draft copy of the year-end report to the Sheriff ahead of submittal to the Board of Supervisors (BOS), to allow for response to the proposed recommendations. The reporting period is August 1, 2022 – August 31, 2023.

The SSO staff has been open, professional, cooperative, and accommodating with the OIG during this reporting period. The SSO has also been very responsive to requests and has provided information to the OIG in a timely and productive manner.

We thank the Board of Supervisors, the Sheriff and his executive staff, the Community Review Commission, as well as the members of the community for their support during this past year.

During the reporting period, the OIG received a total of 140 community contacts. Of that total, 44 were allegations of misconduct, which were forwarded to the Sheriff's Office Internal Affairs Bureau for investigation. 28 were inquiries that did not involve a report of misconduct and were handled by the OIG. 55 involved employees of another jurisdiction, and 11 were related to inmate medical treatment and were forwarded to Adult Correctional Health (ACH) via Internal Affairs.

There were two Officer Involved Shootings and nine In-Custody Deaths that occurred during the reporting period. At the time of this report, all associated investigations were still open and at different stages of review. While the OIG had some immediate involvement or notification of the critical incidents in real time, the completed investigations were not ready for review at the time of this report. Nonetheless, the OIG will add recommendations associated with the critical incidents, where necessary, based on known information at the time of this report.

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 2 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. Inmate medical care is provided in-house by professionals assigned to the Adult Correctional Health division of the Department of Health Services. 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 community 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 an 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 community complaints to be forwarded for investigation
- Attend meetings of the Sacramento County Community Review Commission
- Provide complainants with updates about the progress and outcome of their 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 Community 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

Community Complaint Process

The SSO provides a variety of ways for community members 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. Community members 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 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. Complaints that do not amount to the levels of Categories I or II are usually investigated by the named employee's supervisor. All three categories require that the complaints be logged into the Internal Affairs (IA) complaint software system (IA Pro) and given a complaint number. These investigations are fully logged, tracked, and documented.

Complaint Findings Notification

Quite often the OIG receives complaints from concerned family members of jail inmates. The family member may be independently filing a complaint or may be filing a complaint on behalf of the inmate's request. In the past, IA would only send a final investigation disposition letter to the party initiating the complaint. The OIG saw the need to also inform the inmate of the final disposition of the investigation as well. Internal Affairs command staff agreed and updated their procedures to include a letter to the inmate.

22-1 Recommendation – Complaint Findings Notification

The SSO should inform the complainant and involved party (if different) of the final disposition of the complaint investigation made on their behalf.

Status: ***In Progress and Ongoing***

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 Adult Correctional Health (ACH) 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 response regarding the handling of the investigation of medical treatment complaints sent to ACH has been inadequate.

Within the Sacramento County jails, medical care and treatment is the responsibility of Adult Correctional Health (ACH), a division of the Department of Health Services. When the OIG receives a complaint regarding the medical treatment and care of an inmate, that complaint is forwarded to IA to determine if there was any potential misconduct involvement by SSO personnel.

If there are any allegations of wrongdoing by SSO staff, the complaint is handled primarily by Internal Affairs or the supervisor of the accused staff. If the complaint only involves Adult Correctional Health personnel, the complaint is forwarded to ACH for follow-up and investigation. At the completion of the investigation, an email is sent to IA and forwarded to the OIG with the determined outcome. The response does not include whether the complaint was valid and what corrective actions were taken. Or if the complaint was frivolous and how it was found to be so.

The OIG does not have any supervisory authority over Adult Correctional Health but does have the authority to receive complaints regarding the care they are providing. This misconception

of presumed authority can cause confusion for the members of the community utilizing the OIG to lodge complaints against ACH.

The OIG recommends a process be put in place to allow for full independent review of ACH complaint investigations. The natural source of the complaint investigation would be IA with the OIG to audit the completed investigations.

22-2 Recommendation – Complaints Related to Medical Treatment of Inmates

The SSO should work with ACH to develop an independent complaint investigation review process for complaints referred to ACH by SSO related to the medical treatment and care of inmates.

Status: Pending

Misconduct Investigation Training and Supplies

As discussed earlier, community complaints and misconduct investigations are conducted by investigators assigned to Internal Affairs and by the accused employee's supervisors and/or commanders located at the division level. Newly promoted supervisors do receive some training around 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. It is also important anyone conducting a misconduct investigation has the necessary tools and equipment for the investigation. Audio recordings of complainant and deputy interviews are imperative for the integrity of the investigation.

22-3 Recommendation – Misconduct Investigation Training and Supplies

All supervisors and commanders responsible for conducting community complaint and internal misconduct investigations should receive annual refresher training on misconduct investigation procedures. Those supervisors should also be assigned the necessary equipment to allow them to conduct a thorough investigation.

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) during the reporting period 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. Complaints associated with medical treatment are forwarded to PSD, who then forwards the complaints to Adult Correctional Health (ACH) for review.

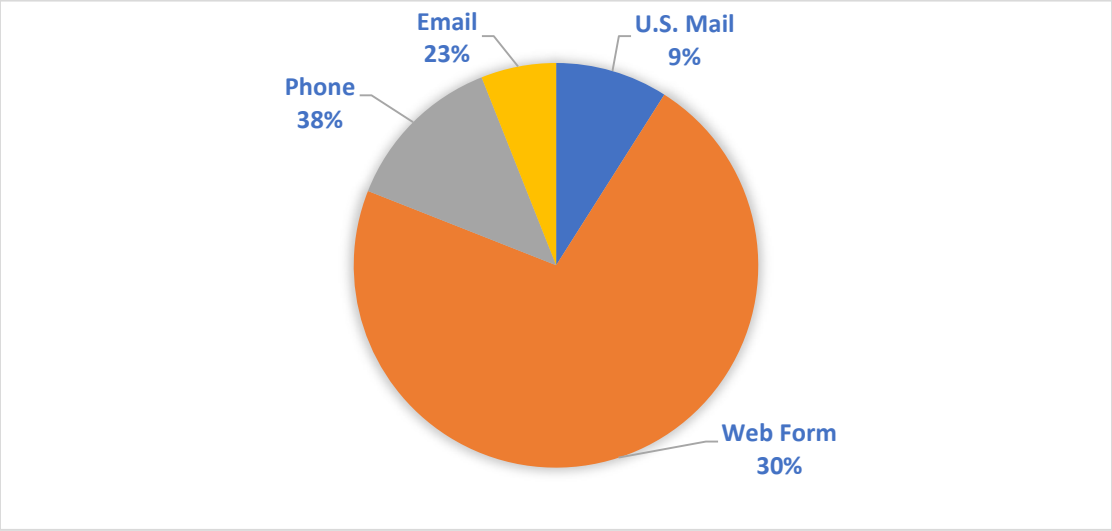
Inquiries involving non-misconduct issues are handled by the OIG. Inquiries can include requests for information, questions regarding policy and practices and complaints of misconduct that involve other agencies. The OIG also logs, documents, tracks, and reviews all Officer Involved Shootings and In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

Method Received and Assignment

The Office of Inspector General received 44 complaints of misconduct by Sacramento Sheriff's Office employees, 55 complaints of misconduct by employees of a different agency, 11 complaints of medical treatment and care inside the jails, and non-misconduct inquires.

All complaints associated with Sheriff staff or ACH was forwarded to Internal Affairs. Complainants with concerns associated with jurisdictions other than Sacramento County were given the contact information for those jurisdictions.

The OIG received a total of **140** complaints and inquiries from August 1, 2022 – August 31, 2023.

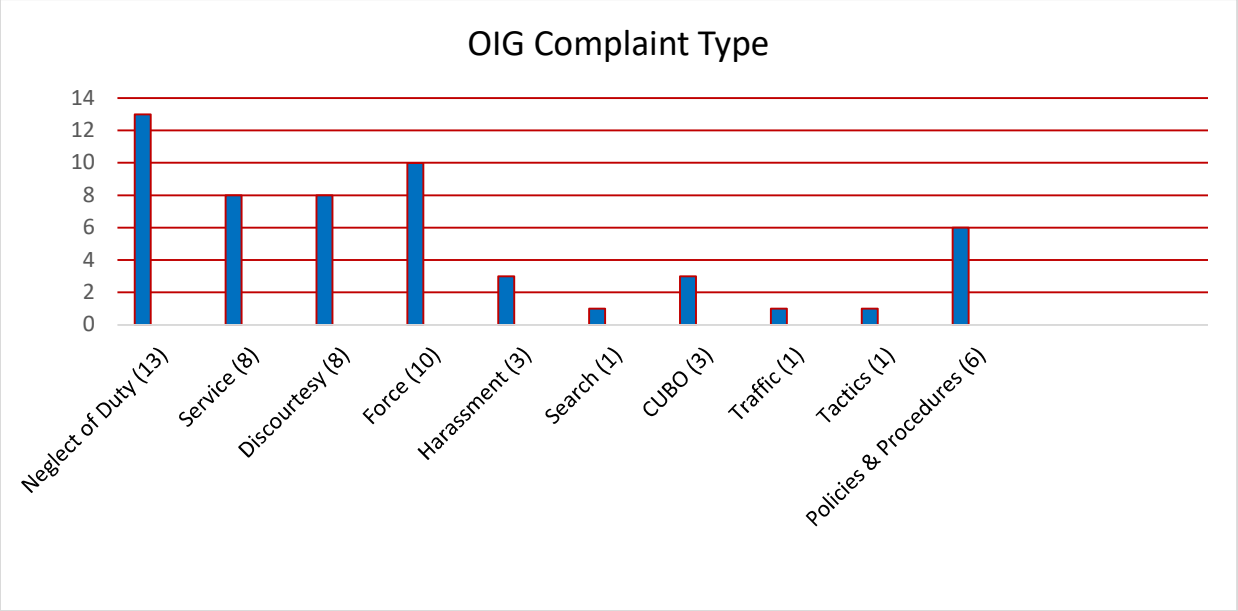


OIG Methods Received

Allegations

The OIG received a total of 55 community complaints of SSO misconduct. These complaints were referred to the SSO for follow-up and investigation. As complaints are received by the Office of the Inspector General, they are assigned an allegation based on the initial information provided. The following chart illustrates the type of complaints that were referred to the SSO during this reporting period. One complaint can have more than one allegation.

In addition to the 55 community complaints, there were also 6 policies and procedures concerns forwarded to the Professional Standards Division.



OIG Complaint Type

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 success.

For the 55 complaints noted in this report, 11 are still open and have not yet been closed with a disposition.

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 community engagement, and promote trust between the police and the communities they serve.

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 community complaints 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.

22-4 Recommendation – Providing Information to the Public

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

Status: Previous Recommendation, Repeated and Pending

OIG Notification of Serious Incidents and Allegations

The Professional Standard Division has 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.

22-5 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: Previous Recommendation, Repeated and Pending

Critical Incidents

Officer Involved Shootings

As of the date of this report, there have been a total of two 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 would have access to the completed files to provide summaries and reviews of these incidents as well as recommendations associated with policies and tactics. Preliminary recommendations where needed are made in this report.

Jaime Naranjo – September 28, 2022

Summary of Facts

On September 28, 2023, Mr. Naranjo's wife called 911 and requested a deputy's assistance. Mrs. Naranjo explained Mr. Naranjo was suicidal due to having trouble sleeping for several days. Mr. Naranjo was threatening to harm himself with a machete.

Three units were dispatched to respond to the call. The first deputy arrived within several minutes of being dispatched. The deputy approached the house and was met by Mrs. Naranjo, who was standing outside and speaking to dispatch on the phone. Shortly after, Mr. Naranjo came to the door while holding the machete. The deputy gave Mr. Naranjo commands to drop the machete as Mr. Naranjo walked in the deputy's direction. When Mr. Naranjo refused to stop and drop the machete, the deputy fired five shots, striking Mr. Naranjo.

Arriving deputies provided medical aid to Mr. Naranjo, but ultimately, he died.
He was 55 years old.

OIG Review

The completed investigation was not done at the time of this report; however, there are some circumstances that arose that the OIG recognized as areas of improvement. Several notable consistent complaints from family members of those involved in critical incidents is the lack of communication surrounding the incident, what are the next steps in the investigative process, when will personal items be released to the family, and updates with the investigation.

22-6 a-d Recommendation – Critical Incident Considerations and Liaison

a. ***The SSO should consider assigning one point of contact to interface with the involved individual's family members post critical incident. This staff should be available to answer questions and make recommendations for resources.***
b. ***Quite often the family home is part of a search that does not allow the family access for several hours. Consideration should be given to allowing the family to remove any needed medication or other necessities prior to their removal from the home.***
c. ***The family of the individual involved in a critical incident should have the first opportunity to view audio and/or video footage prior to its public release.***
d. ***Critical incident investigations can take several months to several years, depending on their complexity. The associated police report is often not available until the***

investigation is completed. A supplemental report outlining all of the necessary facts needed to submit to insurance should be written and provided to the family.

Status: ***Pending***

Vincente Martinez– October 18, 2022

Summary of Facts

On October 18, 2022, Sheriff's dispatch received a call from a woman stating her father (Martinez) had threatened her and her boyfriend. The woman was able to leave the house but informed the Sheriff her father's girlfriend was still in the home and was not allowed to leave. The Sheriff's department was able to speak to Mr. Martinez and he told the negotiator he planned to shoot his girlfriend and a cop.

Mr. Martinez eventually came out of the house with a shotgun in his hand and was holding his girlfriend by the arm with the other hand. Mr. Martinez was immediately shot by two SWAT deputies, firing a total of six shots.

Deputies attempted to provide Mr. Martinez medical aid, but he was pronounced deceased at the location of the shooting.

Martinez was 55 years old.

OIG Review

The investigation was not complete at the time of this report. The OIG did not find the need to issue any immediate recommendations stemming from the available information known at this time.

8/1/2022 – 8/31/2023 In-Custody Deaths

As of the date of this report, there have been a total of nine In-Custody Deaths during this reporting period. 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.

Andre Redmond– August 2, 2022
Justin Smith – August 12, 2022
Kenneth Hicks – November 22, 2022
Keith Still – January 1, 2023
Joseph Wood – January 23, 2023
Delion Johnson – April 5, 2023
Norman Fisher – May 27, 2023
Michael Prince – July 8, 2023
Cody Catanzarite – July 21, 2023

The OIG has not had the opportunity to review the completed investigations associated with the In-Custody deaths during this reporting period; however, a list of recommendations associated with the housing and care of inmates will be listed in this section of the report.

Jail Recommendations

22-7 a-d Recommendations Associated with the Jail

a. ***The SSO should consider using a separate disciplinary scale for mental health inmates that violate jail policies. Removing access to family members (visitation and phone calls) is likely to have a more detrimental effect on the well-being of the inmate than a long-term change in desired behavior.***
b. ***The SSO should consider keeping weather appropriate clothing in a stored, yet accessible area for deputies to give inmates that are released without clothing.***
c. ***The SSO should consider allowing inmates with the desire to have religious specific meals the opportunity to purchase them on commissary.***
d. ***The SSO should consider creating an automated notification system to notify the inmate's next of kin during emergency circumstances when contact with the inmate is not possible. During the winter storm inmates were moved to alternate facilities due to flooding. Many concerned family members contacted the OIG for updates.***

Status: Pending

Other Consideration

Sacramento County, like so many other parts of California, is facing a major health crisis due to Fentanyl overdoses and deaths associated with Fentanyl. The OIG recommends the SSO collaborate with the District Attorney, local fire and rescue, as well as other local law enforcement agencies to create a task force to appropriately recognize Fentanyl overdoses so reports and subsequent investigations can yield dealer arrests and prosecution.