SACRAMENTO COUNTY

Office of Inspector General

2024 Annual 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 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 the national best practices.

One of the challenges presented in compiling this year's report is that the OIG position was vacant from mid-latter part of 2023 until April 2024. During the time the position was unfilled, members of the community continued to leave phone messages and online complaints. With the total number of backlogged complaints numbering in the thousands, the in-coming OIG contacted many of the complainants. Some of the complaints, while time-consuming, were able to be triaged and resolved. Also, while attempting to clear the backlog, the OIG found that some of the complaints had been directed to the Sheriff's Office by complainants. The SSO staff have 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 2024, the OIG received a total of 104 citizen complaints and inquiries. Of that total, 57 were allegations of misconduct. Those misconduct complaints were forwarded to the Sheriff's Office Internal Affairs Bureau for investigation; 5 were inquires that did not involve a report of misconduct and were handled by the OIG; 36 involved employees of another jurisdiction; four were related to inmate medical treatment and were forwarded to Adult Correctional Health (ACH); two were commendations. The SSO processed a total of 81 citizen and internal complaints.

There was a total of seven Officer Involved Shootings and eight In-Custody Deaths reported by SSO during 2024. 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 2024 report. It is anticipated that the DA will complete their reviews in 2025, and these cases will be summarized in the OIG's 2025 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 many high-profile investigations to ensure they were conducted objectively, fairly, and completely. Overall, the OIG found that most investigations were conducted correctly, and SSO staff were diligent in their investigative efforts. Based upon the workload created by the vacancy, the OIG has not been able to formulate a new list of recommendations for the SSO. This report will track and report on the previous recommendations that remained unresolved at the last reporting. The OIG will formulate and present new recommendations in future reporting.

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. 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 patrols 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 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 citizen complaints to be forwarded for investigation
- Attend meetings of the Sheriff Community Review Commission
- 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 does 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.

RECOMMENDATIONS

The last OIG Report, issued by the prior inspector general (2023), included seven recommendations. Those recommendations were listed as "pending". This report will provide a status update for those prior recommendations. No new recommendations were issued for 2025.

Informal Complaint Resolution (2023 OIG Report 22-1)

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: Completed

Complaints Related to Medical Treatment of Inmates (2023 OIG Report 22-2)

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 have been brought to their attention by this office. However, the OIG has found that the response regarding the handling 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 found to be so based on what information.

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 investigation.

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: Declined (SSO has a tracking system for complaints sent to ACH. As an independent entity, ACH retains authority for investigating and reviewing complaints made against ACH)

Misconduct Investigation Training and Supplies (2023 OIG Report 22-3)

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 that 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

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

Status: Completed

Providing Information to the Public (2023 OIG Report 22-4)

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:* *SSO has agreed to complete this recommendation for 2025 complaint data.

OIG Notification of Serious Incidents and Allegations (2023 OIG Report 22-5)

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:* *Completed

Critical Incident Considerations (2023 OIG 22-6 a-d)

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

Jail Recommendations (2023 OIG Report 22-7 a-d)

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:** Completed (SSO listed in Appendix A)*

Complaints & Inquiries Received by the OIG

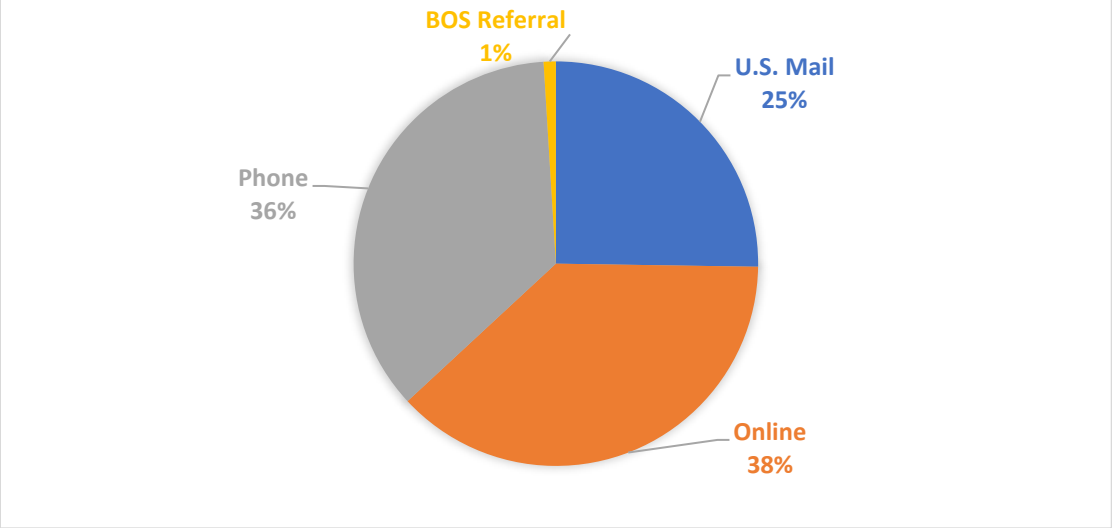
The following represents the method complaints and inquiries were received by the Office of Inspector General (OIG) in 2024 and how those complaints were handled. All complaints and inquiries received by the OIG are logged and documented. Complaints alleging misconduct involving Sacramento County Sheriff's 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

The OIG received a total of **104** complaints, commendations, and inquiries for 2024. Due to the OIG vacancy for much of 2023, there was no end-of-year report issued for 2023. While the sheriff's office continued to compile statistics of complaints they received, no OIG statistics for comparative analysis were available for this report.

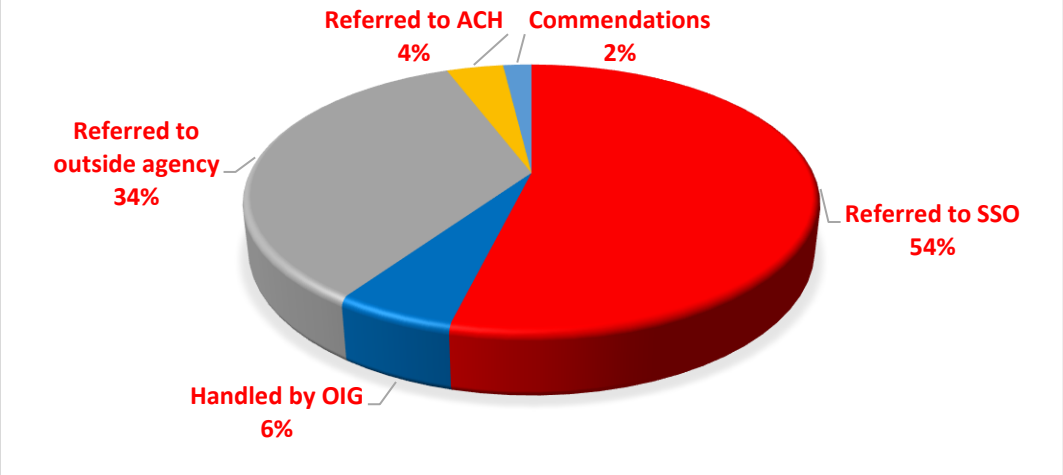
For 2024, the Office of Inspector General received 58 complaints of possible misconduct by Sacramento Sheriff's Office employees, 2 commendations, 36 complaints of misconduct by employees of a different agency, 4 complaints of medical treatment and care inside the jails, and many other non-misconduct inquiries, 6 of which were actionable by the OIG.



OIG Methods Received

Complaint/Inquiry Assignment

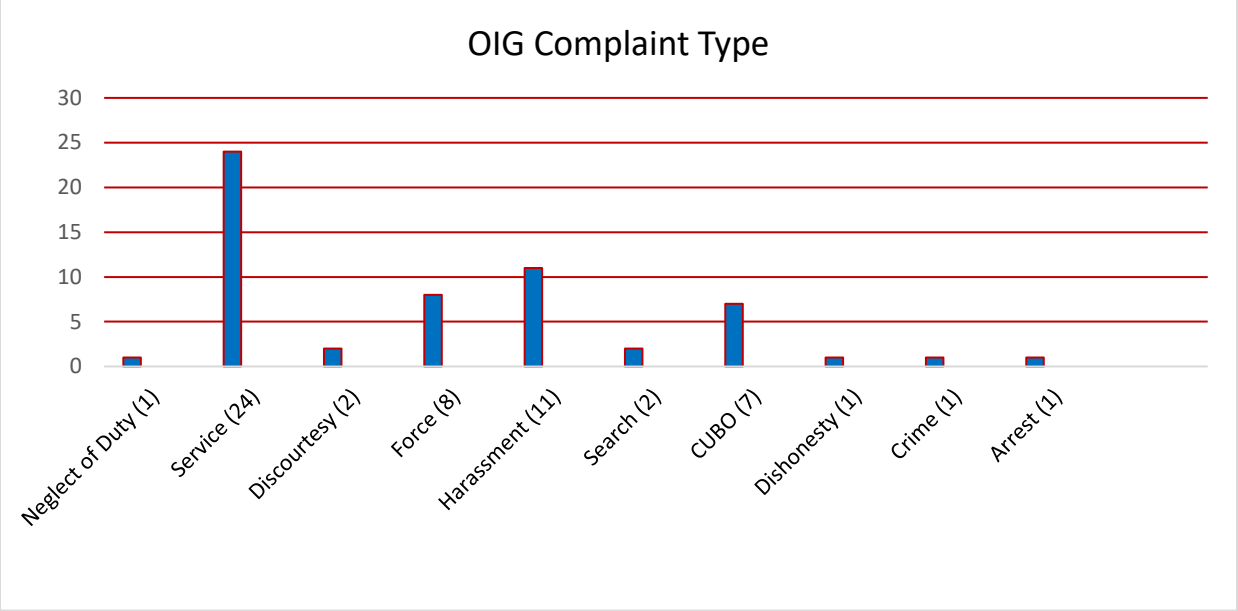
Of the 104 total complaints/inquiries received, 58 were referred to the Sheriff's Office (SSO) for investigation, 6 were handled by the Inspector General (OIG), 36 were referred to outside agencies, 4 were referred to Correctional Health Services (ACH), and 2 commendations were forwarded to the Sheriff.



OIG Complaint Assignments

Complaint Type

In 2024, the OIG received a total of 58 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 2024.



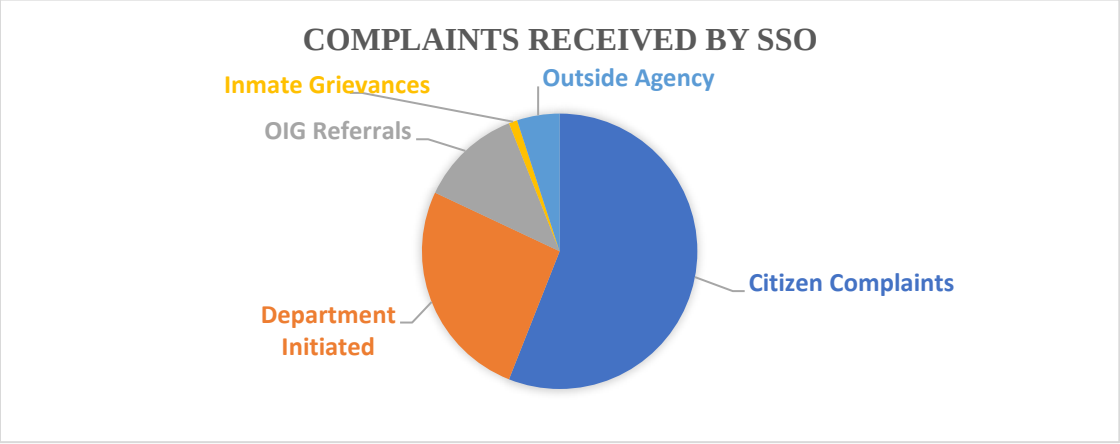
OIG Complaint Type

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 2024, the Sheriff's Office investigated 142 complaints against employees within the Department. Of the 142 complaints, 37 were internally generated by the department, and 105 were citizen complaints. Seventeen (17) of the citizen complaints came through the OIG, eight came (8) from outside agencies, and one was an inmate grievance.

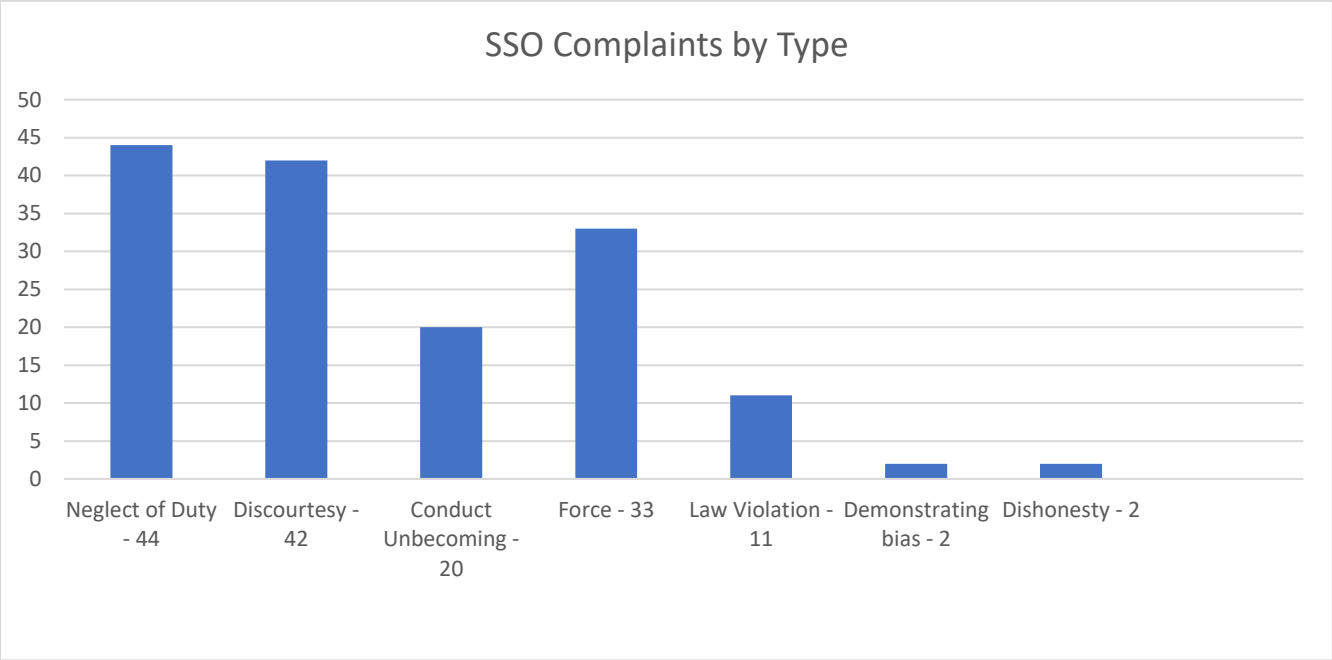


SSO Complaints Received

Note: The total number of complaints recorded by the SSO that were received by the OIG (17) is lower than the total number of citizen complaints reported as received by the OIG (58). This is because 41 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." Also, as previously noted the OIG was vacant until April 2024.

Total SSO Complaints by Type

The 142 complaints investigated by the Sheriff's Office were broken down into 7 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 2024.



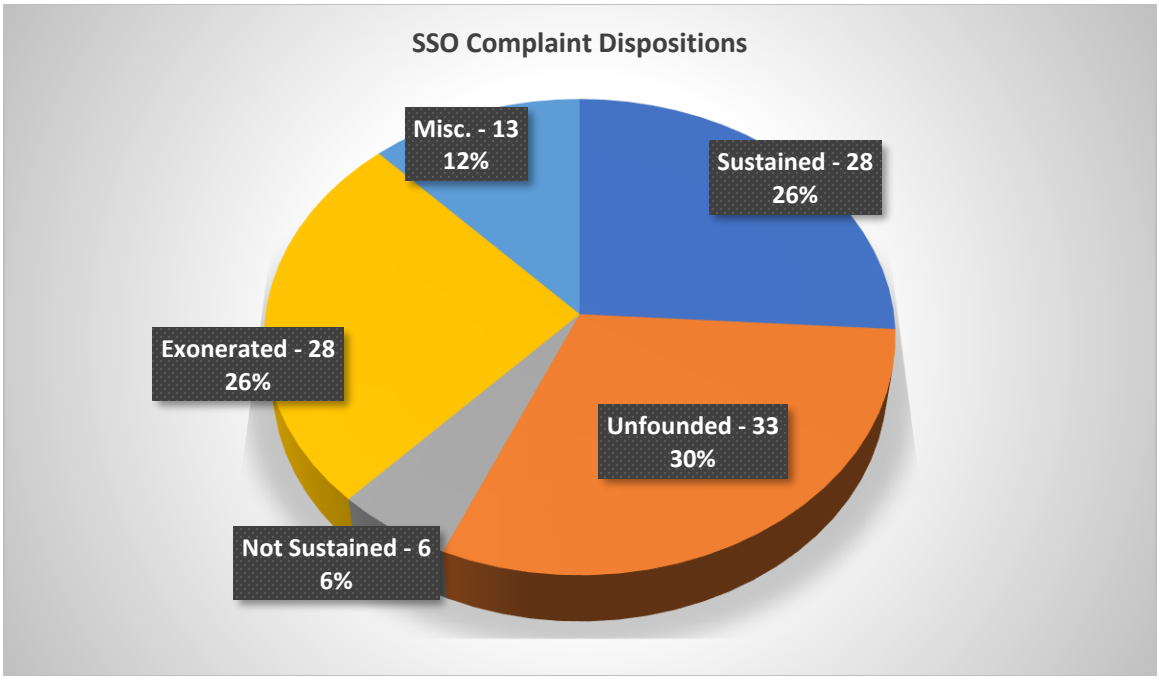
SSO Complaints by Type

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 142 complaints for 2024, 34 are still open and have not yet been closed with a disposition. One hundred eight (108) have been closed. Thirty-three (33) investigations were unfounded, 28 were exonerated, 28 were sustained in whole or in part, 6 were not sustained, and 13 were closed as miscellaneous.



SSO Complaint Dispositions

2024 Officer Involved Shootings

As of the date of this report, there has been a total of 7 Officer Involved Shootings involving deputies from the Sacramento County Sheriff's Office. All but one of 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.

Open Cases

Eric Smith – March 15, 2024
Christopher Gilmore – March 23, 2024
Thomas Konvalin – May 5, 2024
John Frank –July 1, 2024
Israel Price –November 14, 2024
Faisal Mojaddidi – December 30, 2024

Closed Case

Marquis Chapple – March 5, 2024

Summary of facts

On February 5, 2024, Sacramento Sheriff's Office Detectives Bryan Johnson, Kenyan Olsen, and Nathaniel Davis drove a black unmarked Chevrolet Tahoe equipped with an audible siren, forward-facing solid red lights, flashing blue lights, and flashing strobe lights. Detective Johnson was the driver, Detective Olsen sat in the front passenger seat, and Detective Davis sat in the right rear passenger seat.

The detectives wore black bullet-proof vests with star badges on the front and "Sheriff Gang Unit" patches on the front and back. Detective Davis was armed with a department-issued Glock 17 9mm handgun.

At approximately 8:34 p.m., the detectives observed a 2012 Hyundai Tucson drive into The Mart convenience store parking lot on Fruitridge Road in Sacramento County. The detectives noticed the Hyundai drive over a curb while entering the parking lot and followed the vehicle. The Hyundai parked in a stall in front of the store. The front passenger, Marquis Chapple, exited the vehicle and entered The Mart. The driver stayed inside the Hyundai.

The detectives drove past the parked Hyundai to get the license plate number and observed the driver. They also noticed the vehicle's registration was expired. The detectives parked their vehicle in a nearby stall.

Detective Olsen ran a records check on the license plate number and confirmed the Hyundai's registration was expired and suspended.

At approximately 8:35 p.m., Chapple exited The Mart and returned to the front passenger seat of the Hyundai. The detectives decided to contact the Hyundai's occupants due to the vehicle's expired and suspended registration. The detectives activated the Chevrolet's emergency lights, briefly turned on the siren, and parked behind the Hyundai to block the vehicle's path.

Detective Davis exited the Chevrolet and approached the passenger side of the Hyundai. He removed a flashlight from his vest and illuminated the Hyundai's front passenger door area. Detective Davis did not have his firearm drawn.

Chapple opened the front passenger door and quickly exited the vehicle. Chapple had a cellphone in his right hand and a firearm in his left. The firearm was pointed in the direction of Detective Davis. Detective Davis feared for his safety because Chapple pointed the gun at him and the detective was not prepared to defend himself at that moment. Chapple ran between the rear of the Hyundai and the Chevrolet. Detective Davis could clearly see an extended magazine in the firearm and Chapple's index finger near the trigger.

Based on his training and experience, Detective Davis believed it was common for firearms with an extended magazine to be converted into fully automatic firearms. If the firearm was fully automatic, a single pull of the trigger could quickly fire all the rounds in the extended magazine.

As Chapple ran between the Hyundai and the Chevrolet, Detective Johnson exited his vehicle from the driver's side.

Chapple ran in Detective Johnson's direction, and Detective Davis knew that Detective Johnson had exited the vehicle. Detective Davis believed Detective Johnson would not be able to see the firearm in Chapple's hand because the Chevrolet's hood would likely block his view of the firearm.

As Chapple ran behind the Hyundai, Detective Johnson observed Chapple's firearm and yelled, "Don't do it!" Detective Davis saw Chapple run with his arms extended out. Detective Davis observed Chapple look over his left shoulder. Detective Davis believed Chapple was attempting to determine the detectives' location. Because Chapple was running with his arms out, Detective Davis believed Chapple could easily point the firearm backward and fire at the detectives. As Chapple ran, he also looked over his right shoulder.

Based on his training and experience, Detective Davis believed suspects who possess a firearm and decide to flee when contacted by law enforcement officers will typically (1) leave the firearm in the vehicle or (2) flee but quickly discard the firearm. Because Chapple kept possession of the gun and held it in a manner for ready use, Detective Davis believed that Chapple intended to use the firearm.

Chapple continued running in the parking lot towards a civilian on a bicycle. Detective Davis feared for the safety of himself, Detective Johnson, and the civilian on the bicycle. He believed Chapple was going to fire his weapon at them. Detective Davis discharged his firearm three times in quick succession and struck Chapple twice, causing him to fall to the ground and drop his firearm.

Detective Johnson located a Glock 19 firearm with an extended magazine near Chapple. It was later determined, after closer inspection, that the Glock 19 had not been converted to be fully automatic.

Detectives Davis and Johnson detained Chapple and provided immediate medical aid.

At approximately 8:44 p.m., Sacramento City Fire Department Engine 6 and Medic 12 responded to the scene and immediately provided medical aid to Chapple. Chapple was transported to the UC Davis Medical Center. Medical personnel detem1ined Chapple was struck with two firearm rounds. One round struck his left buttock. One round entered the right side of his torso and exited out of the center of his chest.

Detective Olsen contacted and detained the driver of the Hyundai. Law enforcement searched the Hyundai and located a 17-round loaded 9mm Glock magazine in the driver's side door compartment.

Detectives interviewed Chapple. He stated he observed the Chevrolet follow him and the driver into the parking lot and recognized the vehicle as law enforcement. Chapple saw the Chevrolet's police lights and heard the siren. Chapple stated the driver of the Hyundai put the Glock handgun in his lap and told him, "Brother, do something with this." Chapple grabbed the firearm and ran with it in his left hand.

Detectives interviewed the driver of the Hyundai. He stated he was driving the vehicle with Chapple and stopped for a drink. He observed "Gang Taskforce" pull up behind the Hyundai in the parking lot. As he was about to put the vehicle in reverse, he saw the police lights and heard the siren. Chapple ran out of the vehicle, and the driver heard three shots. He stated he did not know Chapple had a firearm and was not aware of the 17-round loaded 9mm Glock magazine recovered from the driver's side door compartment.

Detectives interviewed five witnesses who observed the shooting. All witnesses recognized the Chevrolet as a law enforcement vehicle, recognized the detectives as law enforcement officers, and observed the vehicle's illuminated red and blue lights. Four of the witnesses heard a brief "chirp" from the Chevrolet and commands from the detectives to Chapple. The other witness was deaf. None of the witnesses observed Chapple carrying a firearm before the shooting.

A round count and examination of casings recovered at the scene established that Detective Davis fired three rounds from his Glock 17 9mm handgun.

Body-worn camera videos from Detectives Johnson, Olsen, and Davis and video from security camera systems in the parking lot were reviewed. Due to the frame rates of the video footage, it is unclear whether Chapple looked over his left shoulder. Otherwise, the videos depict the events as described above and clearly show Chapple carrying a firearm before the shooting.

District Attorney Legal Analysis

An 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 affect arrest or detention, to prevent escape, or to overcome resistance. *(Tennessee v. Garner* (1985) 471 U.S. 1, 11; *Graham v. Connor* (1989)
490 U.S. 386, 396; *Kortum v. Alkire* (1977) 69 Cal.App.3d 325; California Penal Code section 835a(b); CALCRIM 2670.) The person being detained or arrested may be subjected to such restraint as is reasonably necessary for his arrest and detention and has a concomitant duty to permit himself to be detained. *(People v. Allen* (1980) 109 Cal.App.3d 981,985; CALCRIM 2670, 2671, 2672.) Officers do not need to retreat or desist their efforts if the person they are arresting or detaining resists or threatens resistance; nor shall the officer be deemed an aggressor or lose the right to self-defense by use of reasonable force. (California Penal Code section 835a(d).)

Here, detectives observed the Hyundai drive over a curb while entering the parking lot. They followed the Hyundai into the parking lot and observed that the vehicle registration was expired.

Detective Olsen ran a records check and confirmed the registration was expired and suspended. Detective Johnson parked the Chevrolet behind the Hyundai to block it from exiting the parking lot and to contact the vehicle's occupants. The officers had reasonable cause to detain the vehicle and its occupants for further investigation.

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; California Penal Code section 835a(c)(l)(A).) 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. (California Penal Code section 835a(a)(4); *Graham v. Connor* (1989) 490 U.S. 386.)

Here, Detective Davis exited the Chevrolet and walked up to the Hyundai. Chapple opened the passenger door and pointed a Glock 19 firearm with a 17-round extended magazine in the direction of Detective Davis.

Chapple quickly fled from the Hyundai's front passenger seat, ran in between the rear of the Hyundai and the Chevrolet, and sprinted down the parking lot in the direction of a civilian on

a bicycle. Chapple ran with the firearm in his left hand in a position for ready use, while moving his arm out. Initially, Chapple ran towards Detective Johnson, who would not have likely seen Chapple's firearm because his view was blocked by the Chevrolet's hood. As he fled, Chapple looked over his shoulders back towards the detectives to determine their locations.

Because Detective Davis feared that Chapple was going to fire his gun at him, Detective Johnson, or the civilian on the bicycle, Detective Davis discharged his firearm three times in quick succession and struck Chapple.

Given these circumstances, Detective Davis's actions were reasonable to protect his safety and the safety of his fellow detectives and the civilian.

District Attorney Conclusion
The detectives contacted the occupants of the Hyundai, which drove over a curb and had expired and suspended registration. When Detective Davis walked up to the Hyundai, Chapple quickly exited the vehicle while pointing a firearm with an extended magazine in Detective Davis's direction.

Chapple quickly fled in the direction of Detective Johnson and ran down the parking lot towards a civilian on a bicycle. Chapple ran with his arm out and holding the firearm in a position for ready use, while looking back in the direction of the detectives.

Fearing for his safety and the safety of the other detectives and the civilian, Detective Davis reasonably believed that firing his weapon was necessary to subdue the deadly threat Chapple presented. His actions were justified under the circumstances.

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.

2024 In-Custody Deaths

There were six In-Custody Deaths in 2024. 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.

Lope Tolosa – May 5, 2024
David Barefield – May 12, 2024
Smiley Martin – June 8, 2024
Juan Rodriquez – June 28, 2024
Asaiah Washington – July 26, 2024
Dawn Vigueras –November 2024

Prior In-Custody Deaths

There was no end-of-year report issued for 2023 due to vacancy in the OIG. The following cases from 2023 are being included to provide an update and Sacramento County District Attorney review/summary.

Keith Still – January 1, 2023

Summary of Facts

Still was transferred from the Alameda County Jail and booked into the Sacramento County Main Jail on June 1, 2022. He was charged with a felony violation of California Penal Code section 245(a)(4) (assault by means of force likely to produce great bodily injury).

Still was found incompetent to stand trial pursuant to Penal Code section 1368 and was pending transportation to a mental health state hospital.

Still was diagnosed with renal failure and his body was not responding to treatment. He was also receiving dialysis treatment.

Still had multiple outside doctor's appointments and hospital admissions, including four separate admissions from November 26, 2022, to January 1, 2023.

At approximately 4:29 a.m. on January 1, 2023, Still returned to the Mail Jail from the U.C. Davis Medical Center. He was placed in cell 2E 308 as the sole occupant.

At approximately 9:25 a.m., Still came to his cell door to receive his medication from a jail nurse during the morning pill call. Sacramento Sheriff Deputy Nathaniel Green noticed Still's right arm looked swollen and asked him if he felt okay. Still said he was fine and took all the assigned medication.

At approximately 10:35 a.m., Deputy Green observed Still standing at his cell door receiving his lunch from an inmate worker.

At approximately 10:44 a.m., Deputy Green observed Still lying down on his bunk during his mandatory hourly security check. Still appeared to be resting normally.

At approximately 11:37 a.m., an inmate worker opened Still's cell door to give him an additional food tray. The inmate worker placed the food tray on the floor and closed the cell door. The inmate worker later reported that Still was alert and told him to place the tray on the floor.

At approximately 11:45 a.m., Deputy Green observed Still lying face down on the floor of his cell during another security check. Deputy Green requested the nurse to assist him in checking Still.

At approximately 11:49 a.m., Deputy Green retrieved a wheelchair and entered the 300 pod with the nurse. Deputy Green and the nurse attempted to wake up Still. Using the emergency button in the cell, Deputy Green requested additional nurses respond with emergency equipment.Deputy Green also requested "Code 3"[1] medical response and began administering cardiopulmonary resuscitation (CPR).

At approximately 11:52 a.m., additional medical staff arrived and assisted in providing medical care to Still.

At approximately 12:00 p.m., Sacramento Fire Department personnel arrived and took over administering CPR. Still was removed from the cell and brought into the dayroom of the pod to receive additional medical care.
At approximately 12:21 p.m., a Sacramento Fire Department paramedic pronounced Still deceased.
Other inmates in the surrounding cells were interviewed. One inmate stated he observed Still "dead" but never reported it. No other inmates reported seeing or hearing anything unusual.

Jail surveillance video was reviewed. The video depicts the events consistently with the description above.

An autopsy was performed by Dr. Jiemin Zhou, a pathologist with the Sacramento County Coroner's Office. Dr. Zhou determined Still's cause of death to be end-stage renal disease due to hypertensive and atherosclerotic cardiovascular disease. The manner of death was classified as natural.

No evidence of criminal misconduct is presented or suggested in any of the supporting reports. Accordingly, 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.

Joseph Lee Wood – January 23, 2023
Summary of Facts

Wood was arrested and booked into the Sacramento County Main Jail on September 24, 2022. He was charged with a felony violation of California Penal Code section 245(a)(I) (assault with a deadly weapon - a knife).

Wood was housed with no cellmate in the Mental Health Housing Unit. He was being held pending a possible placement in the Alta Regional Diversion Program after he was found incompetent to stand trial pursuant to Penal Code section 1368.

On January 23, 2023, Wood was given extra time to shower and missed lunch. At approximately 12:36 p.m., Sacramento Sheriff Deputies Alexandros Sargetis and Alexander Reginato escorted Wood back to his cell and an inmate pod worker gave Wood a peanut butter sandwich.

At approximately 12:48 p.m., Deputies Sargetis and Reginato were notified by another inmate that Wood was lying in an unusual position in his cell and was possibly unconscious. Deputies Sargetis and Reginato, additional deputies, and Sergeant Ken Gouveia all responded to the cell. Deputy Sargetis saw Wood lying in the corner of his bunk. He noticed that Wood's skin was pale in color.

Deputies immediately entered the cell. Deputy Reginato determined that Wood was not breathing and had no pulse. Wood was placed onto the cell floor.

Deputy Reginato began administering cardiopulmonary resuscitation. The Sacramento Fire Department and jail medical staff were called "Code *3."* Jail medical staff responded and suctioned what appeared to be vomit from Wood's mouth.

Fire Department medics arrived at approximately 12:57 p.m. and took over medical aid. The medics noticed Wood's airway was blocked and used suction to clear Wood's airway. An unknown substance was removed from Wood's mouth.

At approximately 1:17 p.m., the Fire Department medics indicated Wood had a pulse.

At approximately 1:20 p.m., Wood was emergency transported to Sutter Medical Center. Wood was pronounced deceased at approximately 11:25 p.m.

Other inmates in the surrounding cells were interviewed and stated that they did not see or hear anything unusual.

Jail surveillance video was reviewed. The video depicts the events consistently with the description above.

An autopsy was performed by Dr. Jason Tovar, a pathologist with the Sacramento County Coroner's Office. He determined Wood's cause of death to be choking on food bolus.[3] The manner of death was classified as an accident.

No evidence of criminal misconduct is presented or suggested in any of the supporting reports. Accordingly, 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.

2025 OIG Focus Areas

Review of Inmate Grievance Procedures

Review of SSO Mental Health Response Policy
The OIG is in the process of reviewing new SSO policy regarding when and how the department will respond to persons experiencing mental health crisis.

Use of Force Trends
The OIG continues to examine 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.

Ongoing Liability Review

Appendix A –List of Recommendations

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: ***Completed***

Complaints Related to Medical Treatment of Inmates (2023 OIG Report 22-2)

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 have been brought to their attention by this office. However, the OIG has found that the response regarding the handling 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 found to be so based on what information.

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 investigation.

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: ***Declined (SSO has a tracking system for complaints sent to ACH. As an independent entity, ACH retains authority for investigating and reviewing complaints made against ACH)***

Misconduct Investigation Training and Supplies (2023 OIG Report 22-3)

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 that 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

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

Status: Completed

Providing Information to the Public (2023 OIG Report 22-4)

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: SSO has agreed to complete this recommendation for 2025 complaint data.

OIG Notification of Serious Incidents and Allegations (2023 OIG Report 22-5)

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: Completed

Critical Incident Considerations (2023 OIG 22-6 a-d)

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

Jail Recommendations (2023 OIG Report 22-7 a-d)

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: Completed (SSO response below)

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.

As agreed to in the consent decree, all mental health inmates who are placed on discipline undergo a rules violation review (RVR) process before discipline is implemented. An RVR includes a review of the incident and the proposed discipline by mental health staff, who then make recommendations based upon the role the inmates' mental health illness played in the incident. The recommendation is then reviewed by a Chief Disciplinary Hearing Officer, who incorporates the recommendation by mental health staff into a final discipline plan. Additionally, inmates who are on the mental health caseload and are placed on discipline are checked by mental health staff to ensure they do not decompensate due to their placement in disciplinary housing.

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.
SSO does have weather appropriate clothing that it provides to inmates who 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.
The Sheriff's Office Correctional Food Services provides religious specific meals to inmates on a regular basis.

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.
Due to the logistical and security issues involved during emergencies that necessitate large scale inmate movement, an automated notification system could not be utilized until the emergency was over. The Sheriff's Office has provided press releases after these emergencies in the past, and will continue to do so to provide inmates' families with updated information.