SACRAMENTO COUNTY

# Office of Inspector General

# 2025 Annual Report

Kevin Gardner
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.

In 2025, the OIG received a total of 86 citizen complaints and inquiries. Of that total, 46 were allegations of misconduct. Those misconduct complaints were forwarded to the Sheriff's Office Internal Affairs Bureau for investigation; two were inquires that did not involve a report of misconduct and were handled by the OIG; 37 involved employees of another jurisdiction; one was related to inmate medical treatment and was forwarded to Correctional Health Services (CHS). The SSO processed a total of 201 citizen and internal complaints.

There was a total of two Officer Involved Shootings and four In-Custody Deaths reported by SSO during 2025. 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 2026 report. It is anticipated that the DA will complete their reviews in 2026, and these cases will be summarized in the OIG's 2026 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. The OIG formulated one recommendation for this reporting period for presentation to SSO. This report will also track and report on the previous recommendations that remained unresolved at the last 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'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 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.

## PAST RECOMMENDATIONS

There are two recommendations from the 2024 OIG Report, which have yet to be resolved. This report will provide a status update for those prior recommendations.

### 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)**

**Update: This recommendation was discussed with SSO executive management. A commitment was given to include complaint investigation data in the department's next annual report. ***The SSO had already completed the annual report for this year before the discussion was held.**

## 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 the necessary facts needed to submit to insurance should be written and provided to the family.**

**Status: Pending**

**Update: SSO responded that there are already processes in place to address the issues raised in this recommendation.**

## NEW RECOMMENDATION

**25-1 Recommendation – Policy Input**

**The SSO should consider seeking input from community stakeholders and partners before changing or implementing policies where such changes will generate an outpouring of local interest.**

**The SSO has the absolute authority to formulate and adopt policy and operating procedures. However, some policies and procedures have community impacts that can be anticipated to generate an many questions and concerns. Such was the impact of SSO adoption of Policy 408- Crisis Intervention Incidents. This policy clarifies when a deputy will be dispatched to incidents involving an individual experiencing a mental health crisis. Much public debate followed the implementation of this policy because the guidelines for response were a departure from past practice where it was routine for SSO personnel to be dispatched to these types of incidents. This policy continues to be a topic of public debate.**

## POLICY CONSIDERATIONS

As indicated previously in this report, the primary function of the OIG is to ensure the integrity of the citizen complaint process for all misconduct complaints involving employees of the Sacramento County Sheriff's Office. However, the OIG also has a responsibility to examine policies and procedures of the sheriff's office and provide recommendations as to whether those

policies and procedures are compliant with the national best practices. To this end, the OIG provides the following information:

The Commission on Accreditation for Law Enforcement Agencies (CALEA) cites a University of Maryland study in making this observation about "best practices";
Best Practices in police management is a term interchangeable with what is often described within other academic disciplines as Evidence based Policy making. The conceptual idea behind both holds that public policies are effective where there is evidence from scientifically sound research studies determining their probability for effectiveness (University of Maryland, 1997 {Link: /https://www.calea.org/sites/default/files/Best%20Practice%20Management.pdf}).

The Sacramento County Sheriff's office contracts with Lexipol for policy management. Lexipol is a company that was founded in 2003 by two law enforcement officers, who were also attorneys. The company's stated goal was to empower public safety leaders with policies and insights, among other guidance, to make confident decisions, based upon best practices, and to reduce liability. Lexipol has grown to over 400 employees, including attorneys and staff, and now provides policies and training to first responders and other government agencies across all 50 states. Some available information indicates the ninety-five percent of California law enforcement agencies contract with Lexipol for their policies.

The reason that it is important to provide this information is to illuminate the difficulty of challenging sheriff's office policies in relation to national best practices. Information provided by Lexipol indicates a robust research and deliberative process for policy creation and maintenance. But with nearly identical policies being adopted by many public safety agencies, throughout the country, little room is left for comparison of industry best practices based on policy alone. The likely vetting of policy will be through the judicial process as incidents occur that highlight and challenge public safety policy and practice.

Of note, SSO Policy 408, while composed by Lexipol, has very limited adoption by public safety agencies.

## Complaints & Inquiries Received by the OIG

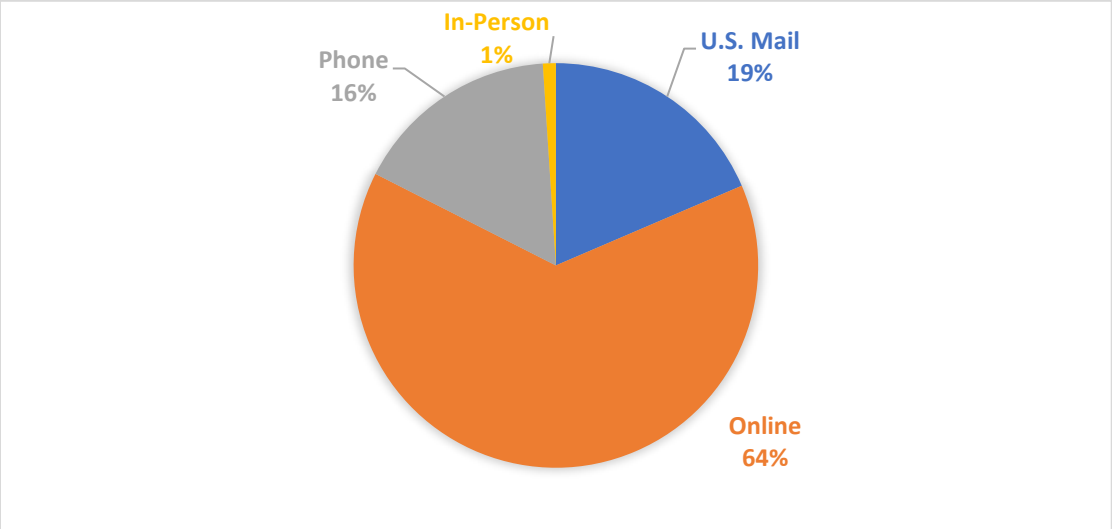
The following represents the method complaints and inquiries were received by the Office of Inspector General (OIG) in 2025 and how those complaints were handled. All complaints and inquiries received by the OIG are logged and documented. Complaints alleging misconduct involving Sacramento County Sheriff's 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 **86** complaints, commendations, and inquiries for 2025. Due to the

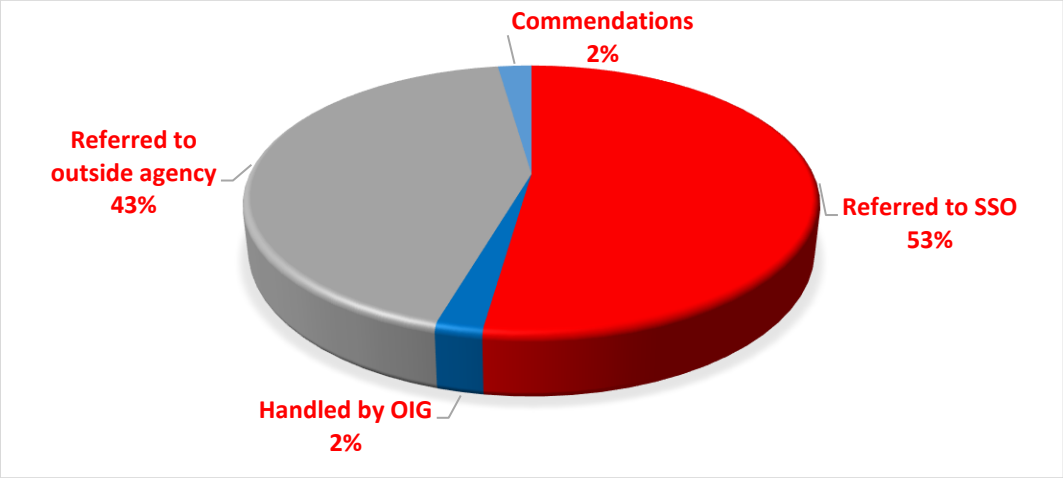
For 2025, the Office of Inspector General received 46 complaints of possible misconduct by Sacramento County Sheriff's Office employees (some of these complaints were custody related and involved a medical component. Complaints concerning medical care were also forwarded to Sacramento County Adult Correctional Health [ACH]), 2 commendations, and 38 complaints of misconduct by employees of a different agency. Of the 46 complaints for possible misconduct by sheriff's office employees, 20 were related to jail facilities.




***OIG Methods Received***

## Complaint/Inquiry Assignment

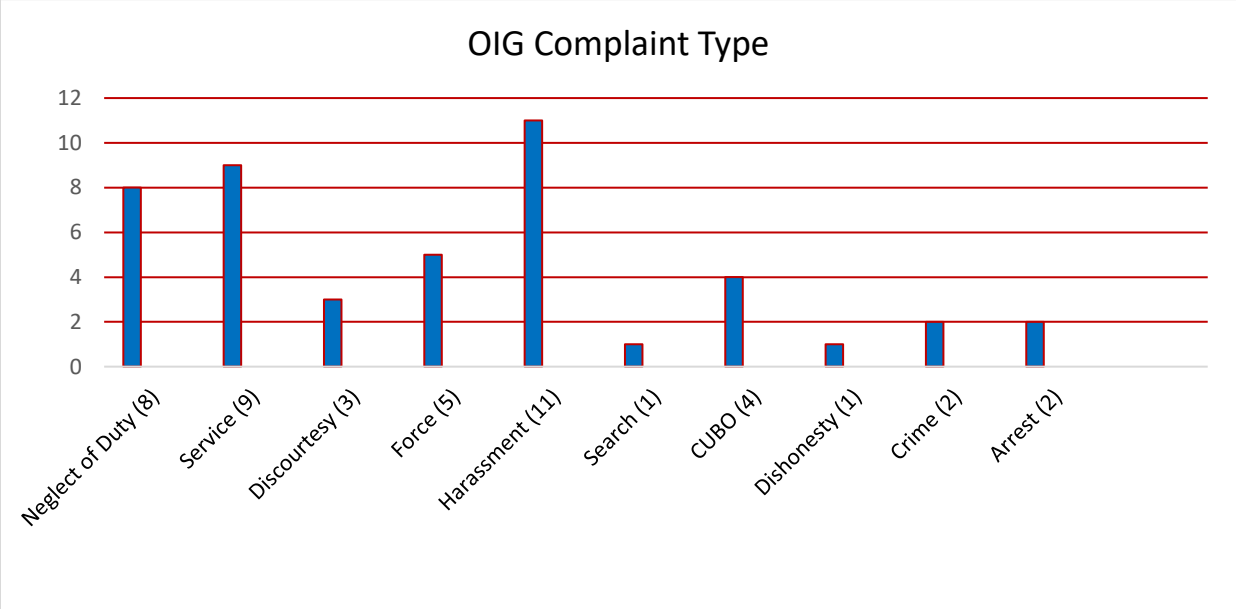
Of the 86 total complaints/inquiries received, 46 were referred to the Sheriff's Office (SSO) for investigation, 2 were handled by the Inspector General (OIG), 38 were referred to outside agencies. Two commendations were forwarded to the Sheriff.




***OIG Complaint Assignments***

### Complaint Type

In 2025, the OIG received a total of 46 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. Upon completion of their review/investigation, SSO may change the complaint type for entry into their database. The following chart illustrates the type of complaints that were referred to the SSO in 2025.



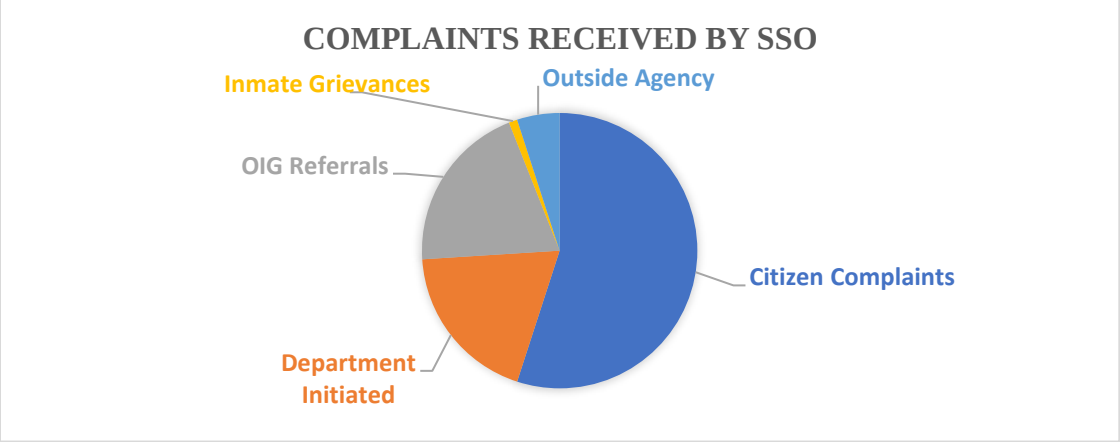

***OIG Complaint Type***

# Complaints Received by the Sacramento Sheriff's Office

The following is information was 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 2025, the Sheriff's Office investigated 199 complaints against employees within the Department. Of the 199 complaints, 37 were internally generated by the department, and 110 were citizen complaints. Forty (40) of the citizen complaints came through the OIG, eleven (11) came from outside agencies, and one was an inmate grievance.

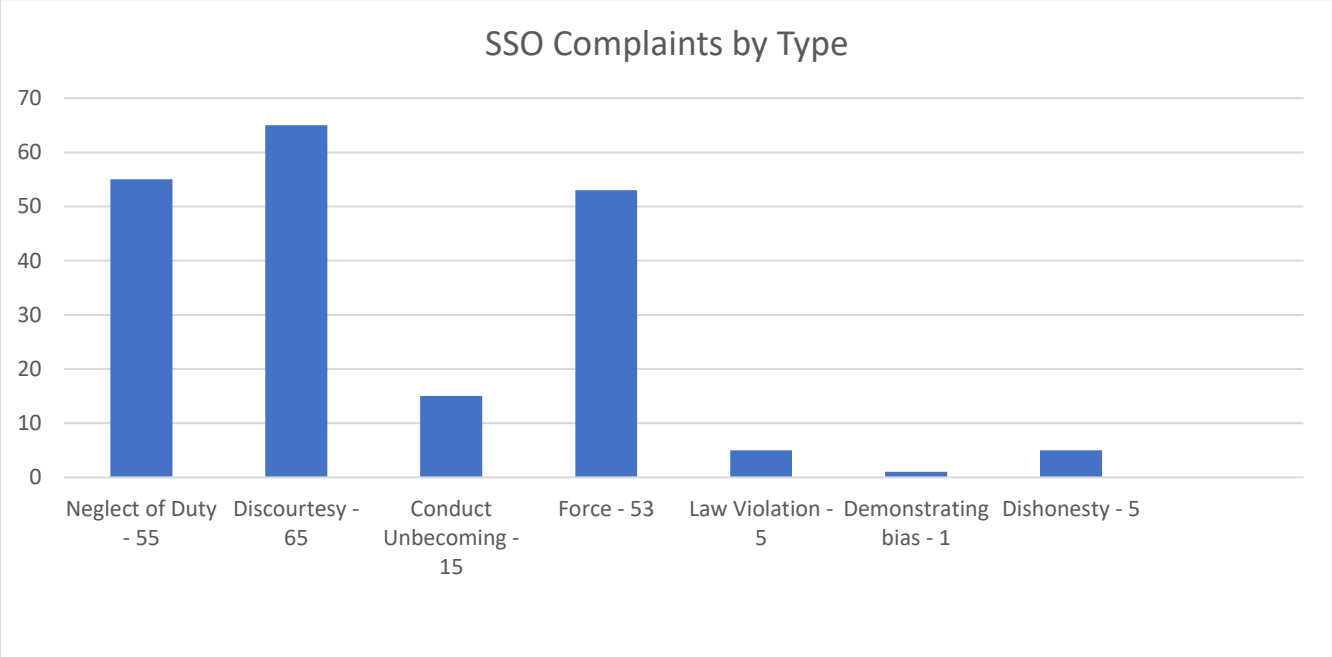



***SSO Complaints Received***

*Note: The total number of complaints recorded by the SSO that were received by the OIG (40) is lower than the total number of citizen complaints reported as received by the OIG (46). This is because six 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 199 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 2025.




***SSO Complaints by Type***

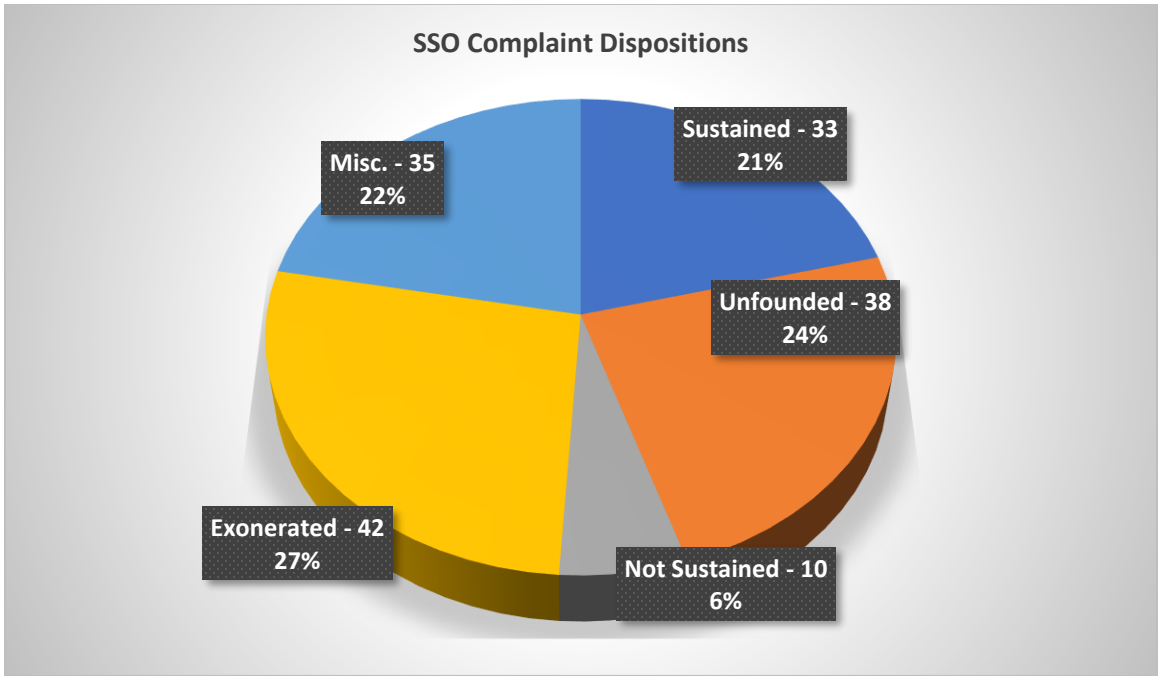
### SSO Complaint Dispositions

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 conclusion.

For the 199 complaints for 2025, 41 are still open and have not yet been closed with a disposition. One hundred fifty-nine (158) have been closed. Thirty-eight (38) investigations were unfounded, 42 were exonerated, 33 were sustained in whole or in part, 10 were not sustained, and 35 were closed as miscellaneous as shown below:

25- Preliminary Inquiry Only (chose not to pursue formal complaint)
6—Withdrawn
2—Within Policy
2—Resigned




***SSO Complaint Dispositions***

## 2025 Officer Involved Shootings

As of the date of this report, there has been a total of 2 Officer Involved Shootings involving deputies from the Sacramento County Sheriff's Office. Both 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.

**Kenneth Vaughn – March 29, 2025**
**Marvin Morales – December 2, 2025**

# Closed Case

**Thomas Konvalin – May 23, 2024**

**FACTUAL SUMMARY**

At approximately 1 a.m., on May 23, 2024, a female 9-1-1 caller reported, "Hurry, hurry, we've been shot." Screaming and gunshots could be heard before the phone call disconnected. Rancho Cordova Police Department (RCPD) and Sacramento Sheriffs Office (SSO) patrol personnel were dispatched to the location of the 9-1-1 call. Upon arrival, patrol personnel observed a female lying motionless on the front lawn of the residence, who was later identified as Thomas Konvalin's mother.

Initial responding personnel heard possible gunshots as they approached the residence, so they took Cover and began to set up a perimeter. At approximately I :22 a.m., Thomas Konvalin emerged from the front door, looked at his mother on the front lawn, and demanded to police, "Stay out of my house." Konvalin was ordered to keep his hands in view, but he refused and then shut the door.

Due to the circumstances and concern of danger in approaching the residence, as well as Konvalin's mother showing no signs of life and appearing to be deceased, patrol personnel set up containment of the residence and requested additional officers and resources. A Critical Incident Negotiation Team (CINT) member made announcements over a marked patrol car loudspeaker (PA) ordering occupants of the residence to come out of the front door with empty hands raised.

At approximately I a.m., a RCPD officer spoke directly to Konvalin. In that phone call, Konvalin stated, "There are two things in my house, and I shot at them." Konvalin repeated the comment and claimed that his parents "were attacking Tommy." Konvalin acknowledged that he was "Tommy," and he was the person that officers previously saw at the front door of the house. Konvalin also admitted shooting two people. When the officer asked Konvalin to come out of the house with his hands up, he refused. The officer asked Konvalin if he was alone in the house. Konvalin indicated he was alone and then hung up the phone.

Further communications with Konvalin were not clean Konvalin stated in one of the calls, "1 told you what happened," and then hung up. In another call, Konvalin stated, "Yeah, I called the army and the people, and they're coming for me. They are coming right now to heal this." Law enforcement again asked Konvalin to come outside, and he stated, "No, I'm fine. I was going to go to sleep. Thanks for helping."

Officers enlisted the aid of another agency's drone device to safely approach Konvalin's mother. Using the drone, they were able to observe her more closely. She was not moving and showed no signs of life.

CINT members continued PA announcements for Konvalin to come out of the house with his hands up and that they did not want to hurt him, as well as phone calls to him. At approximately

I :58 a.m., a CINT member spoke briefly to Konvalin. Konvalin said, "1 tried calling some people to help out. You guys got it? Everything okay now?" He then hung up. At approximately 2:21 a.m., Konvalin said, "I shot Tommy, I shot them. I called the cops and everything. So, that's it for tonight." Konvalin then hung up the phone. Five minutes later, Konvalin again spoke with CINT members. In that phone call, Konvalin provided his name and stated that there was nothing else to talk about and the police could leave the scene. He then hung up the phone again. All further attempts to speak with Konvalin were met with negative results.

Due to the circumstances, the SSO Special Enforcement Division (SED) responded. SED deputies believed that Konvalin shot and killed his mother and possibly his father. While the condition of Konvalin's father was unknown, Konvalin had stated that he shot his parents and the condition of Konvalin's mother was assessed by an on scene medic who examined closer imagery of her via drone footage and could see that she had gunshots wounds to her chest and head and showed no signs of life. SED deputies were also aware based upon records checks of prior mental health calls at the residence involving Konvalin. They were further aware that he was armed with at least one firearm, additional weapons were registered to his father, and that Konvalin was not compliant with all efforts to get him to disarm, exit the house, and surrender over several hours. CINT members also spoke to Konvalin's uncle. He reported that Konvalin called him and stated, "They attacked him, and I think I shot and killed two of them." When Konvalin's uncle asked him what he was talking about, Konvalin hung up the phone.

In order to gain more information and determine the status of Konvalin's father, law enforcement decided to send a drone into the house. At approximately 4:13 a.m., further PA commands were given for Konvalin to exit the house unarmed. An armored vehicle, known as the "Rook," was deployed to break out the front window to deploy the drone.

As part of scene security, SSO Deputies Ken Becker and Benjamin Gil were positioned on a roof north of the residence. Their responsibility was to gather intelligence and to provide scene overwatch and lethal cover, as necessary.

As law enforcement began to break the front window with the Rook, Deputy Becker saw a light illuminate through a rear window with the blinds open, and the window screen pushed out from a back bedroom. Deputy Becker also observed Konvalin exit the window holding what appeared to be a "long gun" (i.e., a shotgun or rifle) and crouching as he moved through the backyard. Deputy Becker was concerned that if Konvalin continued moving to the west, he would lose sight of Konvalin and SED deputies would not be able to see Konvalin as they were on the other side of a fence. Deputy Becker believed Konvalin exited the rear of the residence to avoid the law enforcement presence in front of the house and was positioning himself to ambush deputies and officers. Deputy Becker fired a single shot to prevent Konvalin from being a threat to deputies and nearby residents. Due to the night conditions, Deputy Becker could not confirm whether his shot hit Konvalin.

After the gunshot, Konvalin changed directions and headed toward an RV parked on the north side of the residence. Deputy Becker yelled, "Don't move, don't move, hands up." Konvalin did not respond to these commands, changed directions, and was still armed. As a result, Deputy Gil fired a single shot at Konvalin. Konvalin did not drop his long gun and continued to move forward toward the fence. Concerned that Konvalin was proceeding to the neighbor's yard toward SED deputies, Deputy Becker fired a final shot at Konvalin.

Konvalin fell behind the north fence and out of view. Deputies approached, detained Konvalin, and began to provide medical care. Sacramento Fire Department medics arrived and pronounced Konvalin deceased. Konvalin's father was located inside the residence in the doorway to one of the rooms off the main hallway. Both of Konvalin's parents were also declared deceased at the scene by Sacramento Fire.

The scene was secured and processed by investigators. In the backyard, a Marlin .22 caliber semi-auto rifle was recovered in a shrub near Konvalin's body. The rifle was originally located near Konvalin's feet and moved by deputies prior to securing the scene. The rifle was loaded with 13 live cartridges. Deputies also recovered a Ruger .22 caliber revolver next to Konvalin's body. The pistol was loaded with six live cartridges. A black backpack next to Konvalin's body had 358 live .22 loose cartridges.
Body-worn camera videos were reviewed. The videos depict the events as described above.

Autopsies of Konvalin's parents were performed on May 24, 2024, by Dr. Peter Conner, a forensic pathologist with the Sacramento County Coroner's Office. Dr, Conner determined the cause of death for Konvalin's father to be gunshot wounds to the head and torso. Dr. Conner determined the cause of death for Konvalin's mother to be gunshot wounds to the head and chest.

Dr. Conner also conducted the autopsy of Konvalin on May 27, 2024. Dr. Conner determined the cause of death was gunshot wounds to the head and back.

A sample of Konvalin's femoral blood was obtained during the autopsy. The sample was tested by the Sacramento County District Attorney Laboratory of Forensic Services. The sample tested positive for THC.

**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. l, I l; Graham v. Connor (1989) 490 U.s. 386, 396; Kortum v. Aikire (1977) 69 Cal.App.3d 325; Califomia 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, law enforcement personnel were called out to a shooting incident. As they arrived at the residence, they heard gunshots and observed a deceased person on the front lawn. Deputies and officers ordered Konvalin to exit the residence with his hands up, but he refused their orders. He then admitted to them that he shot two people. There was probable cause to arrest Konvalin, and law enforcement attempted to do so over approximately three hours. However, Konvalin did not give any indication of a willingness to disarm or submit to a lawful arrest. Instead, Konvalin attempted to exit the back window armed with a rifle. As a result, Deputies Gil and Becker reasonably determined that use of force was necessary to effectuate an arrest of Konvalin to protect the safety of their fellow officers and nearby residents.

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)( I )(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. (CALC RIM 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.)

California Penal Code section 835a(c)( I )(B) provides that a peace officer is justified in using deadly force upon a fleeing person if the officer reasonably believes, based on the totality of the circumstances, that such force is necessary "to apprehend a fleeing person for any felony that threatened or resulted in death or serious bodily injury, if the officer reasonably believes that the person will cause death or serious bodily injury to another person unless immediately apprehended. Where feasible, a peace officer shall, prior to the use of force, make reasonable efforts to identify themselves as a peace officer and to warn that deadly force may be used, unless the officer has reasonable grounds to believe the person is aware of those facts."

Deputy Becker and Deputy Gil believed Konvalin killed one person and likely killed another. Konvalin was non-complaint over several hours and armed with a gun. The deputies reasonably believed Konvalin was positioning himself to potentially ambush law enforcement. They also reasonably believed Konvalin presented a deadly threat to any law enforcement personnel he might encounter, as well as any citizens sheltering in place. Because Konvalin was walking in the direction of SED personnel in an adjacent backyard, he presented an immediate threat to their safety and Deputy Becker fired a shot at Konvalin. Konvalin still did not surrender and did not disarm. He proceeded toward personnel on the west side of the residence and had he made it to the RV, he would have been out of their view, so Deputy Gil fired a shot at Konvalin. Konvalin still had not surrendered or disarmed and was again headed back toward the SED personnel positioned in an adjacent yard. Deputy Becker reasonably believed that Konvalin presented an immediate and deadly threat to the safety of law enforcement personnel and nearby residents when he fired a final shot at Konvalin.

Under these circumstances, both deputies were justified in their decision to use deadly force to subdue the imminent and immediate threat being presented by Konvalin.

**District Attorney Conclusion**

Law enforcement had probable cause to arrest Konvalin for two homicides. Both Deputy Becker and Deputy Gil had every reason to believe that Konvalin was a continuing threat to anyone he encountered. When Konvalin emerged from the rear of the residence, he was armed with a gun and was continuing to refuse law enforcement instructions. At that moment, Deputy Gil and Deputy Becker were rightly concerned for the safety of the officers in adjacent yards and any citizens in the area. Their decision to respond with deadly force was justified and necessary to protect the lives of anyone Konvalin would encounter.
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.

# 2025 In-Custody Deaths

There were four In-Custody Deaths in 2025. 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.

**Daniel Thompson – March 13, 2025**
**Katrina Yates – April 24, 2025**
**Mark Hagemeier – June 16, 2025**
**Marlon Atkins – October 07, 2025**

# Prior In-Custody Deaths

The Sacramento County District Attorney review/summary for the following case, from 2023, was received by the OIG in 2025 and is being included to provide an update.

### Delion Johnson – April 05, 2023

**Summary of Facts**
At approximately 3:40 a.m. on April 5, 2023, California Highway Patrol (CHP) officers transported Johnson to the Sacramento County Main Jail after arresting him for assault, shooting from an occupied vehicle, and felon in possession of a firearm. Sacramento County Sheriffs Office (SSO) deputies conducted a pat-down search and body-scan of Johnson, and they obtained his photograph and fingerprints. Johnson was placed into a holding tank with other arrestees.

Between I p.m. and 2:22 p.m., SSO Deputy Patrick York and Deputy Gordon Lahann opened the door to the holding tank several times to place arrestees into or remove them from the tank, The deputies also answered questions from the arrestees. No arrestee alerted any deputy of any medical needs or emergencies.

At approximately 3:42 p.m., SSO Deputy Jason Holiman and an inmate worker approached the holding tank to serve food and conduct a cell check. Deputy Holiman opened the tank door, announced food was being served, and instructed the arrestees to come to the door to receive their food tray.

Several of the arrestees did not respond and had to be woken up. After the inmate worker passed out the dinner trays, Deputy Holiman and the inmate worker noticed Johnson did not get up and claim his tray. The inmate worker entered the holding tank and advised Deputy Holiman that Johnson was unresponsive.

While holding the tank door, Deputy Holiman attempted to wake Johnson several times by tapping his foot, but he did not respond. Deputy Holiman requested that other deputies respond

to the holding tank to assist. Deputy Holiman continued to fry to wake Johnson but did not enter the holding tank without other deputies for officer safety reasons.

At approximately 3:44 p.m., Deputy York an-ived and held the tank door open. Deputy Holiman entered the holding tank and continued to try to wake Johnson. Johnson was motionless, and his eyes were open in a blank stare. Deputy Holiman stayed with Johnson and told Deputy York to alert medical staff.

At approximately 3:45 p.m., Deputy Lahann responded to the holding tank with medical staff. Deputy Holiman and Deputy Lahann removed Johnson from the holding tank to be treated by medical staff.

Medical staff administered a dose of NARCAN [1] to Johnson. Johnson did not respond.

Deputy Holiman requested fire personnel respond "Code 3."2

Medical staff began administering cardiopulmonary resuscitation (CPR) and other lifesaving methods. Deputies relieved the medical staff and began administering CPR.

At approximately 3:48 p.m., medical staff administered additional doses of NARCAN with no response from Johnson.

Deputy Holiman located a plastic bag in Johnson's jacket pocket while administering medical aid. The plastic bag contained a golf ball-sized amount of various blue and white pills.

At approximately 3:54 p.m., Sacramento Fire Department arrived and took over the medical lifesaving procedures.

At approximately 4: 16 p.m., Sacramento Fire Department personnel pronounced Johnson deceased.

Deputies reviewed jail surveillance video from the holding tank. The video depicts the events as follows;

- At approximately 11:48 a.m., Johnson reached into his front jacket pocket and retrieved a clear plastic bag with unknown contents inside. Johnson removed something from the bag and ingested it. He did this several times. Within a few minutes of first ingesting something from the bag, Johnson removed additional materials from the bag and passed them out to other arrestees in the holding tank.
- At approximately 12:08 p.m., Johnson opened the plastic bag again, removed something, and put it in his mouth. He then sat down. Soon thereafter, Johnson appeared to close his eyes and fall asleep. Johnson leaned over and laid on the bench.
- At approximately 12:35 p.m., another arrestee in the holding tank took a jacket and placed it underneath Johnson's head.
- Over the next three hours, three other arrestees tapped and shook Johnson, but he did not respond.

[1] NARCAN is a nasal spray treatment designed to rapidly reverse the effects of a life-threatening opioid emergencyc
[2] Code 3 indicates to consider the call an emergency and to immediately respond with lights and siren as reasonably necessary.

- The remaining video depicts the events as described above.

The plastic bag recovered by Deputy Holiman was consistent with the plastic bag Johnson can be seen on surveillance video removing from his jacket pocket and from which he consumed unknown substances.

A sample of Johnson's femoral blood was obtained. NMS Labs analyzed the sample and determined it contained 3.7 ng/mL of fentanyl.
An autopsy was performed by Dr. Jason P. Tovar, a certified pathologist with the Sacramento County Coroner's Office. Dr. Tovar determined Johnson's cause of death to be fentanyl intoxication. The manner of death was classified as "Accident."

**LEGAL ANALYSIS:**

The Office of the District Attorney reviews deaths that occur while in police custody to assess and apply the law relating to police use of force and to determine if the officers' acts fall within the state laws of criminal responsibility. This office conducted its review by applying the facts of this case to the controlling legal authority.
Johnson was arrested for assault, shooting from an occupied vehicle, and felon in possession of a firearm by CHP officers. The officers transported Johnson to the jail where he was taken into custody by SSO deputies.

Because the deputies' efforts to detain and take Johnson into custody were lawful, and there is no credible evidence to support a finding that any of the deputies tried to ham him, the only possible source of criminal liability is under California Penal Code section 192(b), involuntary manslaughter. The relevant portion of Penal Code section 192(b) defines involuntary manslaughter as a "killing . in the commission of a lawful act which might produce death . . . without due caution and circumspection." The statutory phrase "without due caution and circumspection" has been described by the California Supreme Court as the equivalent of "criminal negligence." (See People v. Penny (1955) 44 Cal.2d 861, 869-880; People v. Stuart (1956) 47 Cal.2d 167, 173-174.)

Under California law, more than ordinary negligence is required to support a charge of involuntary manslaughter. Evidence must prove that a person acted in an aggravated, culpable, gross, or reckless manner, a manner so imprudent as to be incompatible with a proper regard for human life, or in other words, a disregard of human life or an indifference to consequences of the act. (Somers v. Superior Court (1973) 32 Cal.App.3d 961, 968-969.) Further, the evidence must prove that the consequence of the negligent act could reasonably have been foreseen, and it must appear that the death or danger to human life was not the result of inattention, mistaken judgment or misadventure, but the natural and probable result of an aggravated, reckless, or grossly negligent act. (People v. Villalobos (1962) 208 Cal.App.2d 321, 326-328; People v. Rodriguez (1960) 186 Cal.App.2d 433, 437-441.)

Although the term "negligence" is used in both criminal and civil actions, it is defined differently in each. Criminal negligence differs from civil, or "ordinary negligence," in that it requires a finding of more aggravated reckless conduct (i.e., the standard of measuring the conduct itself is greater). Furthermore, criminal negligence requires a higher standard of proof than ordinary negligence (i.e., proof beyond a reasonable doubt). The determination of whether or not conduct rises to the level of criminal negligence must be determined from the conduct itself and not from the resultant harm. (Somers v. Superior Court, supra, 32 Cal.App.3d at p. 969; People v. Rodriguez, supra, 186 Cal.App.2d at p. 440.)

Here, the deputies acted reasonably while maintaining custody of Johnson at the jail. During this time, the deputies interacted with the arrestees in the holding tank, and they were not alerted to any medical needs or emergencies. As Deputies Holiman and the inmate worker served food to the arrestees, they noticed Johnson did not get up and claim his tray. The inmate worker immediately approached Johnson and determined that he was unresponsive. Deputy Holiman responded and unsuccessfully attempted to wake Johnson up. Deputy Holiman requested assistance from other deputies, medical staff, and fire personnel.

The deputies present were not negligent for failure to provide care or monitor Johnson more closely. To the contrary, Deputy Holiman recognized that Johnson had become unresponsive and immediately called for other deputies, medical personnel, and fire personnel. Deputies also administered CPR to Johnson.

The autopsy conducted by Dr. Tovar reinforces this conclusion. Dr. Tovar determined the cause of death to be fentanyl intoxication, and the manner of death was classified by the coroner as "Accident."
Therefore, considering the totality of circumstances, the deputies did not act in an aggravated, culpable, gross or reckless manner. Nor did they act with a disregard for human life or an indifference to the consequences of their actions.

**District Attorney Conclusion**
Applying the controlling legal standards to the factual record in this case, we find no credible evidence to support an allegation of criminal negligence or excessive force against Deputies Holiman, York, or Lahann. Rather, the objective evidence supports a finding that the deputies' conduct was reasonable given the circumstances they encountered.
Accordingly, we 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.

# 2026 OIG Focus Areas

### TBD

### Review of SSO Mental Health Response Policy
The OIG will continue to monitor the discussion and any update regarding this policy.

### 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

**22-4 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)**

**Update: This recommendation was discussed with SSO executive management. A commitment was given to include complaint investigation data in the department's next annual report. ***The SSO had already completed the annual report for this year before the discussion was held.**

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

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

e. **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.**
f. **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.**
g. **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.**
h. **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 the necessary facts needed to submit to insurance should be written and provided to the family.**

**Status: Pending**

**Update: SSO responded that there are already processes in place to address the issues raised in this recommendation.**

## NEW RECOMMENDATION

**25-1 Recommendation – Policy Input**

**The SSO should consider seeking input from community stakeholders and partners before changing or implementing policies where such changes will generate an outpouring of local interest.**

**The SSO has the absolute authority to formulate and adopt policy and operating procedures. However, some policies and procedures have community impacts that can be anticipated to generate an many questions and concerns. Such was the impact of SSO**

**adoption of Policy 408- Crisis Intervention Incidents. This policy clarifies when a deputy will be dispatched to incidents involving an individual experiencing a mental health crisis. Much public debate followed the implementation of this policy because the guidelines for response were a departure from past practice where it was routine for SSO personnel to be dispatched to these types of incidents. This policy continues to be a topic of public debate.**