OFFICE OF THE INDEPENDENT POLICING AUDITOR

Final Investigative Report on the Independent Administrative Review of the In-Custody Death of Allan Tucker, Jr.

Final Report

June 22, 2026

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Independent Polcing Auditor

Table of Contents

Executive Summary

On August 15, 2025, Mr. Allan Tucker, Jr. suffered a medical emergency and died while in the custody of the Alexandria Police Department (APD). Mr. Tucker was arrested for public intoxication and transported to the sallyport area of the Alexandria Detention Center, owned and operated by the Alexandria Sheriff Office. The sallyport section of the detention center is where police officers and detainees await intake processing, medical screening, and booking by the Sheriff's Department. Individuals arrested by APD officers remain in APD custody until they are medically screened and booked by the Sheriff's deputies and employees.

While awaiting booking in the sallyport area, Mr. Tucker remained APD custody for an extended period of time
(approximately 40-45 minutes) due to a shift change within the Sheriff's Office. The lengthy shift change resulted in a delayed medical screening and intake process. As a result, Mr. Tucker never received standard medical screenings by a nurse or qualified medical detention staff. Mr. Tucker became unresponsive during his delayed admission and later died despite life-saving efforts by APD officers and members of the Alexandria Fire Department and EMS
(AFD).

This report presents findings and recommendations following an independent administrative investigation conducted by the Office of the Independent Auditor (Auditor). The investigation assessed whether Alexandria Police Department officers complied with applicable policies and directives, and examines the circumstances surroundings Mr. Tucker's arrest, transport, and custody. The Auditor's jurisdiction to investigate misconduct and critical incidents is limited to the members and policies of the Alexandria Police Department, and therefore it cannot review, investigate, or issue findings on matters of the Sheriff's Office. However, city ordinances authorize the Auditor to analyze systemic gaps and refer matters to outside agencies that may result in additional recommendations to improve interagency accountability, coordination, and reform.

The findings of this report cover APD officer compliance with APD policies, department-level recommendations for training and policy reviews, as well as recommendations to improve interagency coordination with the Sheriff's Department and first responders to enhance safegaurds for individuals in custody. The Auditor's findings and recommendations are seperate and independent from those of the Independent Community Review Board
(Board), who independently assess the Auditor's investigation for fairness, thoroughness, and objectivity, and may ultimately issue its own findings.

Introduction and Scope of Investigation

Introduction

The Office of the Independent Policing Auditor was established by City Council to provide independent civilian oversight of the Alexandria Police Department. The Auditor is appointed by and directly reports to City Council, operating independently from both the Alexandria Police Department and City Manager's Office.

The Auditor is responsible for conducting independent administrative investigations into critical incidents and allegations of police misconduct and reviewing internal investigations conducted by APD. Adminsitrative investigations determine whether APD officers complied with APD directives, policies, and City administrative regulations. The Auditor may also assess broader patterns, practices, and systems that may mpact public trust in local policing.

The Independent Community Police Review Board is a civilian oversight board appointed by City Council to independently review and assess the Auditor's investigations for fairness, objectivity, and thoroughness. The Board conducts public hearing following the completion of the Auditor's investigation, inviting community members to learn abou the investigation, register for public comment, and share their feedback on the incident, investigation, findings and recommendations. Following the public hearing, all findings and recommendations are submitted to the Chief of Police, who has the final authority on corrective actions including discipline.

Authority

City of Alexandria ordinances § 4-1-5 through § 4-1-7 and § 2-4-220 through § 2-4-229 define the structure and authority of civilian oversight of law enforcement in the City. The processes are further defined by a memorandum of understanding (MOU) between the Board, Auditor, and Alexandria Police Department.

Under these authorities, the Auditor is authorized to:

- Conduct independent administrative investigations into allegations of police misconduct and critical incidents regarding death or serious injury in police custody.
- Access all records, evidence, and information necessary to complete an investigation, including unredacted materials.
- Monitor and review internal investigations conducted by APD.
- Issue findings and recommendations regarding officer conduct, policy compliance, and systemic issues to the Board and Chief of Police for review.

Under these same authorities the Board is authorized to:

- Review investigations conducted independently by the Auditor, or internally by the Alexandria Police Department.
- Assess investigations for fairness, thoroughness, and objectivity.
- Schedule and conduct public hearings following the reciept of a final investigative report by the Auditor or APD.

At the conclusion of a public hearing, the Board may take the following actions:

- Concur with all or some of the findings detailed in the investigation report.
- Advise City Council, the City Manager, the APD, and Auditor that the findings are not supported by the information reasonably available to the APD and recommend further review, consideration, or action by the Police Chief.
- Advise City Council, the City Manager, the APD, and Auditor that, in the board's judgment, the investigation is incomplete and recommend additional investigation by majority vote and final approval by City Council.
- Recommend referral of the complaint or investigation to the Commonwealth's Attorney for the City of Alexandria.

After investigation by the Auditor or APD, and review by the Board, all materials are formally submitted to the Chief of Police. If the Chief of Police declines to implement recommendations by the Board or Auditor, the Chief or a designee shall create a written record within 30 days. The written response must be made publicily available and submitted to the City Council, City Manager, the Auditor, and the Board.

Scope of Investigation

This investigation was conducted by the Office of the Independent Auditor in response a critical incident involving the in-custody death of Mr. Allan Tucker, Jr. on August 15, 2025. The investigation is administrative in nature and is distinct from any criminal investigation. A criminal investigation determines whether an officer violated criminal law. An administrative investigation evaluates whether an officer complied with City administrative regulations, and APD policies and procedures, regardless of whether those actions constitute criminal conduct.

Accordingly, the purpose of this investigation is to assess APD officers' compliance with applicable policies and to

identify any individual or system-level issues that may warrant corrective action or reform.

The scope of this investigation is limited to the actions of members of the Alexandria Police Department and the policies and systems within APD. The Office of the Independent Policing Auditor does not have oversight authority over the Sheriff's Office or the operations of the Adult Detention Center. However, the Auditor's investigation will consider issues outside of the Auditor's jurisdiction that may have impacted the circumstances of this incident. Those issues are identified and addressed through recommendations for independent review of the Sheriff Department and transparency.

Overview of Investigative Agencies & Processes Invovled

Critical incidents resulting in serious injury or death in police custody may be investigated or reviewed through multiple separate agencies. Each investigation serves a different purpose and operates under separate authority.

Criminal Investigation – Critical Incident Response Team (CIRT)

The Critical Incident Response Team (CIRT) is a multijurisdictional team of investigators and officers independent of the Alexandria Police Department. The CIRT team responds to critical incidents to process the crime scene, interview officers involved and gather all relevant evidence. The Critical Incident Response Team conducts an independent criminal investigation to determine whether any officer involved violated criminal law. Its findings are reviewed by the Commonwealth's Attorney, who determines criminal charges.

Internal Administrative Investigation – APD Office of Professional Responsibility (OPR)

The Alexandria Police Department Office of Professional Responsibility conducts an internal administrative investigation to determine whether involved officers complied with APD policies, directives, procedures, and regulations. Upon completion, the investigation is reviewed by the Chief of Police, who makes final determinations regarding findings and any discipline.

Independent Administrative Investigation – Office of the Independent Policing Auditor (AIPA)

The Office of the Independent Policing Auditor conducts a separate independent administrative investigation. The Auditor reviews available evidence, including materials from the criminal and internal administrative investigations, and independently assesses whether officer actions complied with APD policy. The Auditor may issue separate findings and recommendations regarding officer conduct, policy compliance, and department-level concerns.

Review & Public Hearing by Independent Community Policing Review Board (ICPRB)

Following completion of the Auditor's investigation, the Independent Community Policing Review Board reviews the Auditor's report and investigative materials for fairness, objectivity, and thoroughness. The Board conducts a public hearing to review the Auditor's report and receive public comment before taking any official action or issuing any additional recommendations consistent with its authority. The public hearing is an opportunity for the public to participate in the civilian oversight process ensuring transparency and accountability in local policing.

The Alexandria Sheriff's Office

The Alexandria Sherrif's Office and Detention Center is a state organization operating in Alexandria Virginia. When an Alexandria police officer makes an arrest, they transport detainees to the Detention Center and reasonably rely on the response from the Sheriff's Department to complete medical screenings, booking, and transfer of custody. Under the current ordinance and MOU, the Auditor and Board do not have authorization to independently review the actions and policies of the Sheriff's Department related to the in-custody death of Allan Tucker, Jr.

Evidence & Methodology

The Office of the Independent Policing Auditor conducted an independent administrative investigation into the in-custody death of Mr. Allan Tucker, Jr. on August 15, 2025. The investigation included review of law enforcement reports, body-worn camera footage, dispatch communications, Fire/EMS records, detention center materials, officer interviews, departmental policies, and relevant personnel and disciplinary records.

The Auditor's investigation focused on whether APD officers complied with applicable policies and procedures during Mr. Tucker's arrest, transport, custody, and detention at the Adult Detention Center. The review also considered whether any broader policy, training, supervision, coordination, or system-level issues contributed to the circumstances surrounding the incident.

Table 1. Evidence Reviewed

Category	Materials Reviewed
Law Enforcement Reports and Investigative Materials	APD incident and supplemental reports; CAD reports and incident detail reports; OPR final investigative memorandum approved by the Chief of Police; CIRT investigative summary report, supplements, and final correspondence; Watch Commander report
Body-Worn Camera Footage and Transcripts	Body-worn camera footage from involved APD officers; associated BWC transcripts; BWC materials provided through internal investigative files
Communications and Dispatch Recordings	DECC radio traffic from August 15, 2025; 911 call recordings from August 15, 2025
Fire and Emergency Medical Services Records	Fire Department Patient Care Reports; EMS response documentation
Medical and Forensic Records	Office of the Chief Medical Examiner report
Detention Center and Sheriff's Office Materials	Adult Detention Center sallyport video footage provided by the Sheriff's Office; documentation concerning intake and booking procedures
Officer Interviews and Statements	Administrative interviews of involved APD personnel; Criminal investigation interviews conducted as part of the CIRT investigation
Applicable Policies and Directives	City Administrative Regulations; Alexandria Police Department Directives
Personnel and Disciplinary Records	Officer internal histories; administrative forms and related documentation
Additional Documentation	Relevant correspondence; memoranda related to detention center intake and medical screening procedures; investigative notes and supporting materials

Table 2. Investigation Timeline

AUGUST 15, 2025

- Mr. Tucker died while in APD custody after being transported to the Adult Detention Center following an arrest for public intoxication.
- Chief of Police immediately notified the Auditor.
- Auditor responded to APD Headquarters and conducted an initial review of available information, including body-worn camera footage.
- Independent Community Policing Review Board members were notified of the incident.

SEPTEMBER 2025 – MARCH 2026

- Auditor continued reviewing available evidence and investigative materials, including body-worn camera footage, reports, dispatch records, medical documentation, and related materials.

DECEMBER 2025

- Critical Incident Response Team (CIRT) completed its criminal investigation.

JANUARY 2026

- Commonwealth's Attorney reviewed the CIRT investigation and declined to pursue criminal charges against the involved officers.

APRIL 2026

- APD Office of Professional Responsibility completed its administrative investigation.
- Chief of Police finalized findings and provided results and recommendations to the Auditor's Office.

MAY 2026

- Auditor reviewed completed investigative materials.
- Independent Community Policing Review Board notified of the status of the investigation.
- Independent administrative report completed.

JUNE 22, 2026

- Final investigation report formally submitted to the Independent Community Policing Review Board.
- Report publicly released.

JUNE 29, 2026

- Public Hearing before the Independent Community Policing Review Board.

What Happened?

Incident Narrative

On August 15, 2025, at approximately 5:07 PM, the Department of Emergency and Customer Communications (DECC) received multiple 911 calls reporting a male running through the hallways of an apartment building, screaming and banging on doors. Callers described the individual as attempting to enter residences and behaving erratically. One caller indicated the individual may have been experiencing a mental health episode or under the influence of a substance, while another referenced a possible weapon, although no weapon was observed. Two officers were assigned to respond, with an additional third officer en route.

At approximately 5:27 PM, Officer 1 (OF1) arrived on scene. Upon entering the building, OF1 encountered Mr. Allan Tucker, Jr., on the first floor. Mr. Tucker appeared visibly distressed, sweating, wide eyes, and was speaking rapidly. When asked if he was okay, Mr. Tucker stated that he was not and reported that someone was inside his apartment with a gun.

OF1 accompanied Mr. Tucker to his apartment and remained in the hallway with Mr. Tucker to address his concerns, attempting to calm him down. An older male, later identified as Mr. Tucker's father, came to the door of Mr. Tucker's apartment and stated that no one else was inside the residence.

Some minutes later, at approximately 5:31 PM, Officer 2 (OF2) arrived and joined OF1 and Mr. Tucker in the hallway. Mr. Tucker continued to report that an unknown individual was inside the apartment and requested a search. OF2 entered the residence to conduct a search while OF1 remained with Mr. Tucker in the hallway.

During the search, at approximately 5:35 PM, Officer 3 (OF3) arrived on scene and remained with OF1 and Mr. Tucker in the hallway. Mr. Tucker continued to repeat that someone was inside the apartment.

At approximately 5:38 PM, OF2 completed the search and reported that no additional individuals were present inside the residence. Based on statements from Mr. Tucker's father, OF2 was advised that Mr. Tucker had left the residence for approximately 45 minutes and returned acting erratically. Despite the completed search, Mr. Tucker continued to insist that an unknown individual with a gun was inside the apartment and refused to go inside.

Officers conducted a second search of the residence with Mr. Tucker's consent, including bedrooms and common areas as Mr. Tucker watched on from the doorway. No additional individuals were located, nor could any be observed on body-worn camera.

At the conclusion of the second search, officers advised Mr. Tucker that the residence was clear and encouraged him to return inside. Mr. Tucker refused, stating that he believed someone was still inside and that he would not re-enter. He pointed to shadows and empty spaces in the common area of his apartment while repeatedly stating he "sees a man with a gun."

At approximately 5:43 PM, OF1 informed Mr. Tucker that he would be placed under arrest for public intoxication if he refused to return inside. Mr. Tucker responded "if I have to go to jail, I go to jail" and did not resist when officers arrested and placed him in handcuffs.

Following the arrest, officers conducted a search incident to arrest. Mr. Tucker remained compliant. Personal property was removed and given to Mr. Tucker's father prior to Mr. Tucker's escort out of the building for transport to the Adult Detention Center. Officer's escorted Mr. Tucker to a patrol vehicle at approximately 5:47 PM.

While seated in the patrol vehicle, Mr. Tucker became increasingly agitated, shouting and requesting to speak with a supervisor. Additional officers arrived on scene but were not involved in the initial encounter. The additional officers spoke with Mr. Tucker through the back window to ascertain if Mr. Tucker took any substances or medication that may have impacted his behavior. At some point, while awaiting the arrival of a Sergeant supervisor, OF1, OF2, and OF3 muted their body-worn camera for a brief period. The body-worn cameras were unmuted after a brief discussion between the officers.

A Sergeant supervisor arrived at approximately 5:58 PM, spoke briefly with Mr. Tucker, and directed OF1 to transport Mr. Tucker to the Adult Detention Center. The supervisor instructed OF1 to "run code" and to notify the jail that they were transporting a disorderly individual to prompt a quck response by Sheriff's deputies.

OF1 complied with the supervisor's direction and OF3 followed behind to support with the transfer of custody at the Adult Detention Center. Prior to departure, DECC dispatch was requested to notify the Adult Detention Center that an officer was en route with a disorderly male in custody. A member of the DECC team notified Sheriff's deputies at the Adult Detention Center. Dispatch stated: "we have officers in route with one disorderly male, just giving you all a

heads up, they should be there in five minutes." The Sheriff's deputy responded "okay, thanks." Transport began at approximately 6:01 PM using emergency lights and sirens.

During transport, Mr. Tucker continued to shout in the backseat and display signs of distress. At approximately 6:04 PM, as the vehicle passed the INOVA Alexandria hospital, Mr. Tucker repeatedly requested to be taken to the hospital. Despite his repeated requests, OF1 continued to transport Mr. Tucker to the detention center.

Around 6:11 PM, OF1 arrived at the Adult Detention Center and communicated with Sheriff's Office personnel through the sallyport intercom. OF1 advised Sheriff's deputies that they had one disorderly male in custody. Sheriff's Office personnel acknowledged the prior communication by DECC dispatch and confirmed Mr. Tucker's identity before permitting entry into the sallyport. OF1 entered the sallyport with Mr. Tucker in the backseat of the police cruiser. OF3 parked outside of the sallyport and walked inside to assist with the transfer of custody.

Upon entry into the sallyport, officers were immediately informed that Mr. Tucker's intake would be delayed due to a shift change in progress. No estimated time for Mr. Tucker's medical screening, intake, and booking was provided.

Mr. Tucker remained in APD custody and the back seat of the patrol vehicle while officers awaited a response from Sheriff's deputies. During this time, Mr. Tucker continued to shout, kick the interior of the vehicle, and exhibit signs of agitation. Officers periodically approached the vehicle, instructing him to stop kicking and calm down.

Between approximately 6:30 PM and 6:45 PM, Mr. Tucker's behavior began to change. His screams decreased and voice became less audible. During this time, officers can be viewed on body-worn cameras checking their phones and pacing as they awaited a response from Sheriff's deputies.

After almost half an hour, at approximately 6:44 PM, a Sheriff's deputy entered the sallyport area and instructed officers to turn off the patrol vehicle. Officers advised the Sheriff's deputy that they had a disorderly individual in custody and were still awaiting intake. No additional information regarding intake and timing was provided by the Sheriff's deputy, who left the sallyport area and returned to the inside of the detention center. Shortly after, officers observed Sheriff's deputies processing another individual for release while Mr. Tucker remained in the sallyport awaiting intake and medical screening. Visible and audible frustration by the officers due to the long wait was observed on body-worn camera.

At approximately 6:51 PM, OF3 approached the vehicle to check on Mr. Tucker after a period of decreased movement and sound. Upon observation, Mr. Tucker appeared unresponsive. OF1 and OF2 immediately opened the vehicle doors and attempted to wake him.

At approximately 6:52 PM, OF1 notified dispatch of a possible overdose and requested emergency medical assistance. The dispatcher called the Sheriff's deputies to notify them of a possible overdose or medical emergency in the sallyport and requested assistance from Sheriff medical staff and employees. The Alexandria Fire Department and EMS was also dispatched for medical assistance. Meanwhile, OF1 administered Narcan and began life-saving efforts while Mr. Tucker remained unresponsive in the vehicle. Naloxone (Narcan) is a life-saving medication that officers may administer when an individual is experiencing a suspected opioid overdose because it can rapidly reverse the effects of opioids and restore normal breathing while emergency medical care is en route.

Officers removed Mr. Tucker from the vehicle and began life-saving measures, including cardiopulmonary resuscitation (CPR). Sheriff's deputies and medical personnel arrived shortly thereafter, however they did not assist APD officers in their attempts to revive Mr. Tucker. Paramedics arrived at approximately 7:00 PM and assumed medical care.

Despite continued life-saving efforts by the APD and AFD/EMS, Mr. Tucker was not able to be revived and pronounced dead at the scene. Due to the extended delay in intake and medical screening, there was no transfer of custody to the Sheriff's Department, and therefore Mr. Tucker remained in police custody at the time of his death.

OF1, OF2, and OF3 were placed on administrative leave immediately following the in-custody death incident. On August 19, 2025 - OF1 and OF3 were formally notified and placed on Administrative Assignment, a temporary assignment pending the outcome of an administrative investigation of critical incidents. While on administrative assignment, police powers remain fully intact. On January 22, 2026, the APD Office of Professional Responsibility initiated its internal administrative investigation into the in-custody death incident to determine whether APD directives and City Administrative Regulations were violated. On February 16, 2026, OF1 and 3 were reinstated to full duty, returning to regular assignments and patrol duties following the conclusion of APD's internal investigation.

The Chief of Police and APD leadership completed its review and approval of the internal investigation and turned over all evidence, including the final internal investigation report to the Auditor on April 8, 2026. The Auditor completed its investigation on May 13, 2026 and notified the Board to schedule a public hearing. The Board recieved the final Auditor's report on June 22, 2026 after it's public release and scheduled a public hearing on June 29, 2026.

Alexandria Fire & EMS Response and Medical Examiner Findings

Fire and EMS personnel responded to the Alexandria Adult Detention Center for a reported medical emergency. Upon arrival, Mr. Tucker was unresponsive, without a pulse, and not breathing. CPR had already been initiated by Alexandria Police Department officers on scene prior to EMS arrival. EMS personnel took over resuscitation efforts and provided advanced life-saving care. Despite these efforts, Mr. Tucker did not regain a pulse. After continued resuscitation attempts, medical control authorized the termination of efforts, and Mr. Tucker was pronounced deceased at the scene.

The Office of the Chief Medical Examiner conducted an independent examination and determined the cause of death to be related to substance intoxication, with the manner of death classified as accidental.

Officers Involved

Table 3. Alexandria Police Department Officers

The following Alexandria Police Department officers were involved in the in-custody death incident on August 15, 2026. All officers identified were acting within the scope of their official police duties at the time of the incident.

Officer	Role	Responsibilities	Length of Service
OF1	Primary responding officer / Arresting officer	First officer on scene; made initial contact with Mr. Tucker; responsible for arrest, transport, and custody at the Adult Detention Center	4 years with the Alexandria Police Department
OF2	Responding officer / Arresting Officer	Assisted with on-scene investigation, including searches of the residence; participated in arrest and post-arrest procedures; did not participate in transport or intake custody	5 years with the Alexandria Police Department
OF3	Responding officer	Assisted on scene, including during arrest, transport, and delayed intake at the Adult Detention Center	5 years with the Alexandria Police Department
Sergeant	Supervising officer	Responded post-arrest; provided supervisory direction; authorized transport to the Adult Detention Center	24 years with the Alexandria Police Department

Table of Penalties and Applicable Authorities

The Office of the Independent Auditor has authorized access to all APD policies, directives, and instructional memos to support its administrative investigation. Additionally, APD officers must adhere to City Administrative Regulations as City employees. All policies considered for the investigation are selected based on the evidence available and officer actions implicating them.

Authority Type	Document	Description
City Code, Ordinances, and Governing Documents	City Code of Alexandria § 4-1-5 through § 4-1-7	Office of the Independent Policing Auditor
City Code, Ordinances, and Governing Documents	City Code of Alexandria § 2-4-220 through § 2-4-229	Independent Community Policing Review Board
City Code, Ordinances, and Governing Documents	Memorandum of Understanding (MOU) between the City of Alexandria and the Alexandria Police Department	Governing agreement between City and APD
Alexandria Police Department Directives and Regulations	APD Directive 2.8	Body-Worn Camera policy
Alexandria Police Department Directives and Regulations	APD Directive 10.01	Adult Arrests
Alexandria Police Department Directives and Regulations	APD Directive 10.1.08(A)	Medical Care for Arrestees
Alexandria Police Department Directives and Regulations	APD Directive 10.27	Prisoner Transport
Alexandria Police Department Directives and Regulations	APD Directive 10.27(H)(1)	Prisoner Transport (Medical Attention)
City Administrative Regulations	Administrative Regulation 6-20	Performance Standards (Group I - III Offenses)

Additional Authorities and Applicable Policies

The Alexandria Police Department Mission & Oath:

Each police officer in Alexandria has sworn an oath to support the Constitutions of the United States and the Commonwealth of Virginia, and to faithfully and impartially discharge their duties. The mission of the Alexandria Police Department is to “provide competent, courteous, and professional police services in partnership with our community. We are committed to safeguarding life and property, maintaining public order, and fostering a safe environment where all people feel respected and protected. Through transparency, accountability, and collaboration, we strive to build lasting trust while upholding the highest standards of integrity, service, and community engagement.”

Employee (Officer) Rights During Investigations

During the administrative investigation, officers are provided with a written explanation of their rights and responsibilities. They are told what the investigation is about, who is conducting it, and that interviews will take place at a reasonable time and place. Officers are required to answer questions fully and truthfully about their actions while on duty, and failure to do so can lead to discipline.

This process involves due process for officers. Any statements they are required to make as part of the administrative investigation cannot be used against them in a criminal case. However, those statements can be used to determine whether department policies were followed and whether any administrative action is necessary. Officers do not have an attorney present during these interviews.

Intake Screening and Medical Clearance Process

The Alexandria Sheriff's Office has established procedures to ensure that individuals are medically and mentally appropriate for intake into the Alexandria Adult Detention Center. In 2024, a memo written by the undersheriff was sent to public safety partners, including the Alexandria Police Department. The memo details procedures for intake and medical screenings for people transported to the Adult Detention Center. It is not a formal policy or directive of the police department.

The memo provides an overview of Sheriff Office procedures for medical screenings prior to intake and booking. Typically, when officers arrive at the sallyport in the Adult Detention Center, they must wait for Sheriff's Office employees to complete intake and admit detainees into the jail. The intake process includes a medical screening by a nurse or otherwise qualified medical professional in the Sheriff's Office. However, the medical screening does not commence until Sheriff employees commence intake.

As outlined in a March 20, 2024, memorandum to public safety partners, individuals who present with certain medical or mental health conditions are not accepted into the jail for booking. Instead, those individuals must be transported by the arresting law enforcement agency to a hospital for evaluation, treatment, and medical clearance prior to admission.

This screening and rejection process is intended to occur when an individual arrives at the detention center to ensure that those in need of medical care are identified and diverted to a hospital without delay.

Findings and Recommendations

Table 4. Personnel Findings

Officer	Directive / Policy	Finding
Officer 1 (OF1)	Administrative Regulation 6-20 (Group I – Performance Standards) APD Directive 2.8 – Body-Worn Camera APD Directive 10.1.08(A) – Medical Care for Arrestees APD Directive 10.27(H)(1) – Prisoner Transport (Medical Attention)	Sustained on all identified policy violations
Officer 2 (OF2)	APD Directive 2.8 – Body-Worn Camera	Sustained
Officer 3 (OF3)	APD Directive 2.8 – Body-Worn Camera Administrative Regulation 6-20 (Group I – Performance Standards)	Sustained on all identified policy violations
Sergeant 1	No applicable policy violations identified - referred for further review for possible additional violations by Board	Not Sustained / No violation

Personnel Findings Continued

Officer 1 (OF1)

Finding 1: Professional Standards – City Administrative Regulations

Applicable Policy:
Administrative Regulation 6-20 (Group I – Performance Standards)

Allegation:
That Officer 1 failed to meet performance standards in the transport and monitoring of an arrestee in custody.

Facts:
During the incident, Mr. Tucker exhibited signs of distress, including erratic behavior, agitation, and repeated requests for medical assistance. OF1 continued to transport Mr. Tucker to the Detention Center. OF1 also stated several times that Mr. Tucker was “tripping on something”, detailing his erratic speech, dilatated eyes, and profuse sweating to colleagues and supervisor. While awaiting intake at the sallyport, Officer 1 failed to consistently monitor Mr. Tucker while he awaited intake.

Analysis:
Administrative regulations require officers to maintain performance standards consistent with departmental expectations, including in the care and custody of individuals. The investigation determined that Officer actions during transport and while awaiting intake were not consistent with City administrative regulations.

Finding:
Sustained

Finding 2: Body-Worn Camera

Applicable Policy:
APD Directive 2.8 – Body-Worn Camera

Allegation:
That Officer 1 improperly used the mute function of the body-worn camera during an active incident.

Facts:
Body-worn camera footage reflects that Officer 1 muted the camera while the incident remained active and while Mr. Tucker was in custody and in their presence. No verbal justification for muting was provided.

Analysis:
Directive 2.8 requires officers to articulate a justification when muting a body-worn camera and limits use of the mute function to circumstances where the scene has stabilized and the individual in custody is no longer in the officer’s immediate presence. These conditions were not met at the time the camera was muted.

Finding:
Sustained

Finding 3: Medical Care and Prisoner Transport

Applicable Policies:
APD Directive 10.1.08(A) – Medical Care for Arrestees
APD Directive 10.27(H)(1) – Prisoner Transport (Medical Attention)

Allegation:
That Officer 1 failed to comply with departmental policy regarding the provision of medical care to an arrestee during custody and transport.

Facts:
During transport, Mr. Tucker made repeated statements requesting to be taken to a hospital. These requests occurred as the patrol vehicle passed a hospital and continued during transport to the Adult Detention Center. Officer 1 acknowledged these statements but continued transport to the detention center rather than seeking medical evaluation.

Analysis:
Directive 10.1.08(A) requires that arrestees who request medical treatment be transported to a hospital for evaluation prior to booking. Directive 10.27(H)(1) further requires officers to seek medical attention if a prisoner

becomes sick or injured while in custody.

The investigation determined that Mr. Tucker made multiple statements indicating a desire for medical care. While Officer 1 interpreted these statements as part of Mr. Tucker's altered mental state, the directives do not condition the obligation to seek medical care on an officer's assessment of the credibility or cause of the request. Rather, the policies establish a clear requirement that such requests be addressed through appropriate medical evaluation.

Based on the totality of the circumstances, the decision to continue transport to the detention center rather than seek medical evaluation was not consistent with these directives.

Finding:
Sustained

Officer 2 (OF2)

Finding 1: Body-Worn Camera Compliance

Applicable Policy:
APD Directive 2.8 – Body-Worn Camera

Allegation:
That Officer 2 improperly used the mute function of the body-worn camera during an active incident.

Facts:
Body-worn camera footage reflects that Officer 2 muted the camera during the incident while Mr. Tucker remained in custody and the scene was ongoing. No verbal justification for muting was provided.

Analysis:
Directive 2.8 requires officers to articulate a justification when muting a body-worn camera and limits use of the mute function. These conditions were not met at the time the camera was muted.

Finding:
Sustained

Officer 3 (OF3)

Finding 1: Body-Worn Camera Compliance

Applicable Policy:
APD Directive 2.8 – Body-Worn Camera

Allegation:
That Officer 3 failed to comply with body-worn camera requirements during an active incident.

Facts:
Body-worn camera footage reflects that Officer 3muted the camera during the course of the incident while Mr. Tucker remained in custody and the scene was ongoing. No verbal justification for muting was provided.

Analysis:
Directive 2.8 requires officers to articulate a justification when muting a body-worn camera and limits use of the mute function to circumstances where the scene has stabilized and the individual in custody is no longer within the officer's immediate presence. These conditions were not met at the time the camera was muted.

Finding:
Sustained

Finding 2: Professional Conduct

Applicable Policy:
Administrative Regulation 6-20 (Group I – Performance Standards)

Allegation:
That Officer 3 engaged in conduct inconsistent with departmental standards of professionalism during an active incident.

Facts:
During the period in which officers were awaiting intake at the Adult Detention Center, Officer 3 made a profane

statement directed at Sheriff's Office personnel while in the sallyport area. This occurred while Mr. Tucker remained in custody and during an ongoing incident.

Analysis:
Administrative Regulation 6-20 requires officers to maintain professional conduct consistent with departmental standards, including during interactions with other agencies and while engaged in official duties. The use of profane or disparaging language in an operational setting is inconsistent with these expectations and undermines professional standards.

Finding:
Sustained

Sergeant

Based on the available information, Sergeant 1 did not violate departmental policy. The Sgt. promptly responded to the scene upon Mr. Tucker's request to speak to a Sergeant prior to his transport to the Adult Detention Center. The Sgt.'s actions are recommended for further review by the Independent Community Police Review Board to determine whether the Sergeant's response was consistent with APD supervisory responsibilities.

Departmental & Organizational Recommendations for the Alexandria Police Department

Recommendation 1: Training Gaps in Body-Worn Camera Compliance

Issue:
The investigation identified recurring deficiencies in body-worn camera compliance.

Analysis:
Sustained violations in this case, reflect ongoing challenges in adherence to Directive 2.8 (Body-Worn Camera)

Recommendation:
The Alexandria Police Department should implement enhanced, agency-wide refresher training focused on Directive 2.8 Body-worn Camera for all newly hired officers, patrol officers and sergeants. Training should focus on the following:

- Proper use of the mute function
- Articulation and documentation requirements
- The importance of maintaining transparency during active incidents

Recommedation 2: Policy Review: Prisoner Transport and Medical Decision-Making

Issue:
The investigation identified a need for clearer policy guidance regarding medical screenings and decision-making prior to and/or during prisoner transport.

Analysis:
Directive 10.27 (Prisoner Transport) and Directive 10.1.08(A) (Medical Care for Arrestees) establish requirements related to medical care, however, this case highlights the extent to which application of these directives may rely on officer interpretation, particularly in situations involving intoxication, altered mental state, or repeated requests for medical assistance.

While police officers are often first responders to a variety of health and mental health related emergencies, they are not trained medical professionals. The circumstances of this incident demonstrate the potential for variability in decision-making when clear thresholds or guidance for determining medical need are not explicitly defined within policy.

Recommendation:
The Alexandria Police Department should conduct a comprehensive review of Directive 10.27 and 10.1.08(A), with particular attention to provisions related to medical care and transport decisions. This review should assess whether current policy provides sufficiently clear and actionable guidance for officers who must make split second decisions while faced with difficult circumstances of medical distress. The focus of this training should also center around the application of crisis intervention principles during encounters involving individuals in distress.

As part of this review, the Department should consider the following along with best practices in custodial care and risk reductions for those experiencing medical emergencies:

- Establishing clearer guidance or thresholds for officer-initiated medical transport
- Clarifying how repeated requests for medical assistance should be evaluated and addressed
- Identifying circumstances under which arranging medical screening prior to transport should be required

The objective of this review should be to ensure that departmental policy supports consistent, informed decision-making and reduces reliance on subjective interpretation in high-risk situations. Lastly, the Department shall implement training on the new policy during CIT training for all officers.

Recommedation 3: Dash-Cams

Issue:

Following Mr. Tucker's arrest, he was placed in the back of a police cruiser for transport to the Alexandria Detention Center. He remained in the cruiser until his medical emergency. Throughout transport and during his wait at the Adult Detention Center, Mr. Tucker can be heard screaming and moving around in the back seat. Unfortunately, due to the lack of dash-cams in Alexandria Police vehicles, it is unclear ….

Recommendation:

Prioritize the implementation dash-cams for transparency and thorough review of incidents involving detainees in the back seat of police cruisers.

Interagency Response Assessments & Systemic Reforms

Assessment 1: Limited Alternatives for Individuals Experiencing Intoxication or Impairment

Issue:
The Auditor's investigation identified limitations in available response options for individuals experiencing intoxication or substance-related impairment. The City of Alexandria closed it's detoxification center in 2020 due to limited use and resources. Instead, the City established a partnership with Arlington County, to transport individuals eligible for admittance to the detoxication center based in Arlington.

Analysis:
As current practice, APD officer's rely on the urgency and response of Sheriff's deputies and medical team to provide a prompt examination for individuals in need of a medical screening. Individuals are typically transported either to the detention center or to a hospital, depending on officer assessment. However, the City's partnership and use of the Arlington County detoxification center is available to officers as an additional resource for individuals who do not clearly meet the threshold for hospital transport but may still require medical monitoring or stabilization.

Recommendation:
The Department should review it's current policies regarding medical transport to ensure it is updated with all available options, including the detoxication center in Arlington County. Furthermore, the Department should clearly communicate the updated policy to all patrol officers for their awareness during CIT training.

Alternatively, the City Council and City Manager's Office may evaluate the feasibility of reestablishing a detoxification or diversion facility in Alexandria to provide a direct response option within the next five years

The City's evaluation may include:

- Analysis of trends in public intoxication calls for service
- Review of arrest patterns and outcomes for intoxication-related offenses
- Assessment of current reliance on detention and emergency departments
- Consideration of staffing, operational, and cost implications

Assessment 2: Absence of Pre-Booking Medical Screening Safeguards

Issue:
The investigation identified a gap in medical screening for individuals in custody prior to detention center intake.

Analysis:
Under current practice, individuals in custody may not receive medical evaluation until after admission into the detention center, unless officers independently determine that medical care is required. This approach places primary responsibility for medical decision-making on the arresting officer and does not provide a consistent, independent layer of medical assessment prior to booking.

The circumstances of this incident highlight the potential risks associated with reliance on officer assessment alone

in situations involving intoxication or altered mental state.

Recommendation:
The City's Health and Safety Committee and City Manager's Office should explore interagency partnerships between emergency personnel including the Alexandria Police Department and Alexandria Fire Department & EMS to provide pre-booking medical screening for individuals in custody. The goal is to provide police first responders with::

- Clear criteria for when Fire/EMS evaluation is requested
- Defined roles and responsibilities between APD and AFD/EMS
- Standardized documentation and communication procedures
- Integration with existing dispatch and response systems

Assessment 3: Interagency Coordination and Intake Delay

Issue:
The investigation identified coordination challenges during the transfer of custody at the Adult Detention Center, including a delay in intake.

Analysis:
Mr. Tucker remained in the sallyport for approximately 40–45 minutes prior to the onset of a medical emergency while awaiting admission to the detention center. During this period, officers were informed that a shift change was in progress, and no estimated intake time was provided.

While the Office of the Independent Policing Auditor does not have oversight authority over the Sheriff's Office or detention center operations, the delay in intake and the absence of clearly defined coordination protocols during this period affected the circumstances of the incident.

Recommendation:
Concerns related to detention center intake and operational delays should be referred for independent review within the next year. The City should request an assessment of detention center operations on the date of the incident, including:

- Timeline from arrival to medical emergency
- Staffing levels and operational conditions
- Intake procedures and prioritization
- Communication between APD and Sheriff's Office
- Relevant policies and operational constraints

Potential reviewing entities may include appropriate state or independent oversight bodies.

Assessment 4: Limitations in Oversight of the Sheriff's Office and Adult Detention Center

Issue:
The investigation identifies limitations in the City's ability to oversee accountability and operations of the Sheriff's Department. These limitations include a gap in civilian oversight authority to access Sheriff systems and records, review and investigate allegations of misconduct inconsistent with state and City regulations, as well as critical incidents resulting in death or serious injury of those within the custody and care of the Sheriff's Department.

Analysis:
The Office of the Independent Policing Auditor does not have oversight authority over the Sheriff's Office or the Adult Detention Center, as civilian oversight in Alexandria is established through municipal and state codes that limit jurisdiction to the Alexandria Police department. The Sheriff's Office is a state office that operates outside of established framework.

While City Code authorizes the Auditor to identify and refer matters beyond its jurisdiction to other state and municipal agencies, the City is limited in its ability to conduct a comprehensive, independent review of critical incidents that involve both police and sheriff operations. In this case, key details such as the activity in the jail, shift change, and delayed intake procedures are outside the scope of direct review by the Auditor.

Recommendation:
Circumstances related to the detention centers operations and intake delays should be formally referred to an independent agency for review, if an independent investigation by the Auditor is not possible due to jurisdictional limitations. The current authorities and structure of civilian oversight in Alexandria is standard, and in some aspects, more expansive that neighboring municipalities and states. However, the Sheriff's Office is not subject to the civilian

oversight process, as its state office status and lack of jurisdictional authority over detention facilities govern.

Given the current structure, City Council, the City Attorney's and the City Manager's Office may consider exploring legal options to expand oversight at the state and municipal level to include independent investigations and review of Sheriff and detention personnel and operations. This is also supported by at least a handful of community complaints received via 311, in support of expanding oversight authority to the Sheriff's Office. Furthermore, expansion of oversight authority to detention centers reflects a broader national trend over the past decade in which jurisdictions have begun to examine or implement independent oversight of jails and prisons.

If the expansion of civilian oversight authority is not feasible at this time, Council may consider establishing an alternative independent oversight mechanism to review detention-related incidents by establishing a memorandum of understanding between the City and Sheriff's Office or by partnering with state agencies such as the Commonwealth Attorney's Office and Virginia Department of Corrections for further guidance.

Assessment 5: Need for Formalized Interagency Coordination Protocols

Issue:
The investigation identified the absence of formalized, cross-agency coordination protocols for critical incidents involving multiple public safety entities.

Analysis:
This incident involved coordination among APD, the Sheriff's Office, Fire/EMS, and dispatch personnel. The investigation identified opportunities to strengthen communication, clarify roles, and standardize response procedures across agencies during critical incidents.

Recommendation:
The City should establish a formal interdepartmental workgroup to review and strengthen interagency coordination protocols. This workgroup should be assembled with urgency, prior to the next critical incident which is impossible to know when. The workgroup should:

- Identify communication and coordination gaps
- Establish clear roles and responsibilities across agencies
- Develop standardized escalation and response procedures
- Recommend policy and training improvements

Participants should include APD, the Office of the Independent Policing Auditor, DECC, AFD/EMS, the Sheriff's Office, OCCE, the Office of the City Manager, and the City Attorney's Office.

Assessment 6: Memorandum of Understanding (MOU) Revision and Implementation

Issue:
The investigation identified the need to refine aspects of the Memorandum of Understanding (MOU) between the Board, Auditor, and Police Department.

Analysis:
This incident represents one of the first instances in which the MOU has been fully implemented in practice. The investigation identified areas where clarification related to timelines, coordination, and interagency responsibilities may improve consistency and effectiveness.

Recommendation:
The upcoming MOU review should incorporate lessons learned from this incident, with particular attention to:

- Clarifying timelines and expectations
- Strengthening coordination and communications provisions

Conclusion

This investigation examined the circumstances surrounding the in-custody death of Mr. Allan Tucker and assessed whether the actions of Alexandria Police Department personnel complied with applicable policies and procedures.

The findings identify both individual and system-level issues that contributed to the conditions under which this incident occurred.Sustained violations related to officer performance,body-worn camera compliance,and custodial decision-making reflect deficiencies in the application of departmental policy during a critical incident.At the same time,this investigation highlights broader challenges related to training,policy clarity,interagency coordination,and the availability of appropriate response options for individuals experiencing impairment or altered mental state.

This case also underscores the complexity of incidents that involve multiple agencies and stages of custody.While the Office of the Independent Policing Auditor's authority is limited to the review of the Alexandria Police Department,the circumstances of this incident demonstrate the importance of clear coordination,defined responsibilities,and consistent safeguards across all points of contact.

The recommendations outlined in this report are intended to address both individual accountability and systemic risk. Strengthening policy guidance, enhancing training, improving interagency coordination, and expanding available response options are critical to reducing the likelihood of similar outcomes in the future.

The goal of this report is not only to assess compliance, but to identify opportunities for improvement that support accountability, transparency, and public trust.

Ameratu Kamara

Ameratu Kamara, Independent Policing Auditor

June 22, 2026
Date Signed