



# PUBLIC HEARING INFORMATION HANDOUT

## *In-Custody Death of Allan F. Tucker II.*

Office of the Alexandria Independent Policing Auditor | Independent Community Policing Review Board



### ABOUT THE AUDITOR & REVIEW BOARD

The office of the Alexandria Independent Policing Auditor (AIPA) and the Independent Community Policing Review Board (ICPRB) were established by the City of Alexandria to provide independent civilian oversight of the Alexandria Police Department (APD).

The Auditor is appointed by and reports directly to City Council and operates independently from both APD and the City Manger's Office.

#### THE AUDITOR IS AUTHORIZED TO:

- ✓ Conduct independent administrative investigations into allegations of police misconduct and critical incidents.
- ✓ Access investigative records and evidence.
- ✓ Review APD internal investigations.
- ✓ Issue findings and recommendations regarding officer conduct, policy compliance, and systemic issues.

#### THE ICPRB:



Is a civilian board appointed by City Council.

The Board reviews investigations for fairness, objectivity, and thoroughness and conducts public hearings following critical incidents and completed Auditor investigations.



### INCIDENT SUMMARY

On August 15, 2025, Allan F. Tucker II died while in the custody of the Alexandria Police Department after being arrested for public intoxication and transported to the Alexandria Adult Detention Center.

- Mr. Tucker displayed signs of distress and repeatedly stated someone in his apartment had a gun.
- During transport, he requested to be taken to the hospital, but officers continued to the detention center.
- Intake was delayed due to a Sheriff's Office shift change. Mr. Tucker remained handcuffed in the patrol vehicle in the jail sallyport while awaiting intake and medical screening.
- He became quieter and less responsive. At approximately 6:51 p.m., officers found him unresponsive.
- Officers began CPR, administered Narcan, and requested emergency medical assistance.
- Alexandria Fire/EMS assumed care, but Mr. Tucker was pronounced deceased.
- The Medical Examiner determined the manner of death to be accidental due to substance intoxication.



### UNDERSTANDING CUSTODY & BOOKING

- ✓ Individuals arrested by APD remain in police custody until formally accepted and booked by the Sheriff's Office.
- ✓ Prior to booking, detainees are expected to receive medical screening from jail medical personnel.
- ✓ Mr. Tucker was never formally admitted into the jail because intake was delayed during shift change operations.
- ✓ Because intake never occurred, medical screening by jail medical personnel never occurred.
- ✓ Mr. Tucker remained in APD custody at the time he became unresponsive

# PERSONNEL FINDINGS



## OFFICER 1 SUSTAINED FINDINGS

- Failure to meet performance standards during custodial monitoring.
- Improper body-worn camera muting.
- Failure to seek medical evaluation after repeated requests for hospital transport.



## OFFICER 2 SUSTAINED FINDINGS

- Improper body-worn camera muting.



## OFFICER 3 SUSTAINED FINDINGS

- Improper body-worn camera muting.
- Unprofessional conduct during the incident.



## SERGEANT NO POLICY VIOLATIONS SUSTAINED



## SYSTEMIC FAILURES IDENTIFIED

- Extended intake delay at the Adult Detention Center.
- Failure to provide timely medical screening before booking.
- Lack of clear protocol's during transfer of custody between APD and Sherriff's Office personnel.
- Overreliance on officer discretion for medical transport decisions.
- Insufficient safeguards for intoxicated or impaired detainees.
- Gaps in interagency communication and accountability.
- Limited civilian oversight authority over detention center operations.



## KEY RECOMMENDATIONS

- ✓ Enhanced APD training on body-worn camera compliance and custodial care.
- ✓ Review and revision of prisoner transport and medical care policies.
- ✓ Development of pre-booking medical screening safeguards.
- ✓ Formalized interagency coordination protocols between APD, Sherriff's Office, EMS, and dispatch.
- ✓ Independent review of detention center intake procedures and operational delays.
- ✓ Exploration of expanded civilian oversight or alternative accountability mechanisms for detention operations.
- ✓ Clarification and refinement of the Memorandum of Understanding (MOU).



## NEXT STEPS

- ✓ Findings and recommendations will be formally submitted to the Chief of Police for response and implementation consideration.
- ✓ If recommendations are declined, the Chief of Police must provide a written explanation to City leadership and the public.



## ADDITIONAL RESOURCES

The full Auditor report, related meeting materials, and additional information are available through the City's AIPA and ICRPB webpages.



## SCAN HERE

To access the AIPA website.