Civilian Review Board
Incident Review Report
In-Custody Death Review

Case Information

Date of Case Review: February 25, 2026

Date of Report: March 6, 2026
Case Number: 2025-0048
Date of Incident: October 12, 2025
Location of Initial Response: Private Residence, Richmond, Virginia
Medical Facility: Richmond Community Hospital
Law Enforcement Agency: Richmond Police Department

Officers Involved:

- Officer A
- Officer B
- Officer C

Decedent:

- 58-year-old female

Nature of the Complaint / Review

This review was conducted by the **Civilian Review Board Subcommittee** following an in-custody death involving members of the Richmond Police Department. The purpose of the review was to evaluate the circumstances surrounding the police response, transport, and subsequent medical incident that resulted in the death of a 58-year-old female who was being transported for mental health evaluation pursuant to an Emergency Custody Order.

The Subcommittee examined the available summary report, officer reports, and body-worn camera footage to determine whether the involved officers acted in accordance with department policy and professional standards.

Incident Overview

On October 12, 2025, officers with the Richmond Police Department responded to a 911 call placed by the decedent's mother requesting assistance with her adult daughter, who was reportedly experiencing a mental health crisis. The caller indicated that her daughter, who typically communicates verbally, had become non-verbal and was exhibiting concerning behavior.

Officer A arrived at the residence first and attempted multiple times to engage the individual in a calm, clear tone. The body-worn camera footage reflects that the individual did not respond verbally to these attempts.

Officer A requested additional assistance, and Officer B subsequently arrived on scene. Both officers continued attempts to communicate with the individual and explained to her that her mother had requested assistance due to concerns regarding her well-being.

The officers advised the individual that an Emergency Custody Order (ECO) had been issued and that she would be transported to the hospital for evaluation and treatment. Despite these explanations, the individual remained largely non-verbal. When officers prepared to transport the individual, she requested a pair of sneakers. Officer B assisted in retrieving the footwear, and the individual's mother helped place the shoes on her. The individual was

then escorted from the residence, handcuffed, and placed in the front seat of Officer A's patrol vehicle for transport to Richmond Community Hospital. The individual was placed in the front seat of Officer A's vehicle due to the officer's vehicle not being properly equipped to permit the individual to be transported in the back seat. During transport, the individual did not verbally communicate with Officer A.

Hospital Interaction and Medical Event

Upon arrival at Richmond Community Hospital, officers experienced a brief delay while hospital staff located an available treatment room. During this time, hospital staff attempted to triage the individual by taking vital signs and obtaining blood samples; however, the individual initially refused and remained non-verbal.

Once a treatment room became available, Officers A and B escorted the individual to the room. Officer C arrived shortly thereafter and joined Officers A and B.

The individual was placed in a hospital bed with assistance from Officer A, while Officers B and C addressed paperwork and administrative matters with hospital staff.

When medical personnel attempted to draw blood from the individual, she became physically defensive, prompting hospital staff to request additional assistance. At the request of nursing staff, Officer A removed the individual's handcuffs so that medical staff could safely proceed with treatment.

Body-worn camera footage from Officer C documented the subsequent events. Following the blood draw, the individual's body appeared to become rigid and contorted. A nurse can be heard asking whether the individual was experiencing a seizure.

Medical staff confirmed that the individual was actively seizing and immediately initiated emergency life-saving measures.

Officers A, B, and C exited the treatment room and remained outside while medical personnel continued medical intervention. Despite these efforts, hospital staff ultimately pronounced the individual deceased.

Evidence Reviewed

The Civilian Review Board Subcommittee reviewed the following materials as part of this investigation:

- Richmond Police Department Internal Affairs Division investigative summary report
- Body-worn camera footage from Officers A, B, and C

Administrative Review and Prosecutorial Declination

Following the incident, Officer A was advised of Miranda rights consistent with departmental policy. All required departmental reports and documentation were completed and submitted.

The incident was reviewed by the Richmond Commonwealth's Attorney's Office. After reviewing the circumstances of the case, the Commonwealth's Attorney's Office issued a declination letter stating that no criminal wrongdoing was found on the part of Officers A, B, or C in their interaction with the individual.

Civilian Review Board Analysis

The Civilian Review Board Subcommittee conducted an independent review of the available documentation and body-worn camera footage.

The review found that officers responded to a request for assistance related to a mental health concern and acted in accordance with established procedures for executing an Emergency Custody Order. Officers made repeated

attempts to communicate with the individual using calm verbal engagement and provided explanations regarding the reason for transport to a medical facility.

The Subcommittee also observed that officers complied with requests from medical personnel once the individual was in the hospital setting, including removing handcuffs to allow medical staff to administer treatment.

Based on the materials reviewed, the Subcommittee did not identify actions by the officers involved that were inconsistent with department policy or professional standards.

Findings

Upon review of all available evidence, including body-worn camera footage and official reports, the Civilian Review Board Subcommittee concurs with the findings of the Internal Affairs Division.

The Subcommittee finds that:

- The responding officers acted in accordance with Richmond Police Department policies and procedures.
- Officers responded appropriately to a mental health-related service call and executed the Emergency Custody Order as required.
- Officers complied with medical staff requests during the hospital interaction.
- No evidence of officer misconduct, wrongdoing, or negligence was identified.

Conclusion

Based on a review of the evidence and the findings outlined above, the Civilian Review Board Subcommittee determined that the actions of Officers A, B, and C were consistent with departmental policy and appropriate under the circumstances. The Subcommittee presented its findings for review by the full Board, which concurs with and adopts the Subcommittee's determination that no wrongdoing or negligence was committed by the Richmond Police Department personnel involved in this incident.

Civilian Review Board
Subcommittee Review Panel
Richmond, Virginia