City of Albuquerque
Civilian Police Oversight Agency

ALBUQUERQUE CIVILIAN POLICE OVERSIGHT

Diane McDermott
Executive Director

To: **Kenneth Johnston, A. Commander IAPS**

From: **Diane McDermott, Executive Director**

Subject: **CPOA Report on In Custody Death APD Case # 24-0014087**

Incident Summary:

The incident occurred on February 18, 2024. Two officers were dispatched in response to a service call near the intersection of 98th St SW and Gibson Blvd SW when they encountered a driver operating a vehicle in the wrong direction, who narrowly avoided a head-on collision with their marked patrol vehicles. One officer swerved to evade the impending collision, while the second officer disengaged from the initial call and reversed their patrol vehicle to pursue the wrong-way driver, activating lights and sirens.

The officers observed the individual fail to stop at the stop sign at the intersection. After traversing the intersection, the individual briefly reduced speed before accelerating, driving over a curb and mounting the sidewalk on the northern side of the roadway. The vehicle collided head-on with a guardrail. The driver exited the vehicle and attempted to flee on foot, proceeding northbound, where he became entangled in a downed barbed wire fence, subsequently falling to the ground.

Officers approached and subsequently placed the individual in handcuffs. The individual appeared to be intoxicated, exhibited incoherent speech, and was unable to walk unaided. Upon the arrival of additional officers, they transported him to the pavement on Gibson Blvd SW to await medical assistance. While on the pavement, the individual began to experience a series of seizures. The officers removed his handcuffs, positioned him in the recovery position, and monitored his breathing and pulse until medical personnel arrived on the scene. The Bernalillo County Fire Department (BCFD) arrived at the location, took custody of the individual, provided on-scene medical care, and ultimately pronounced the individual deceased. An autopsy conducted by the Office of the Medical Investigator (OMI) determined the cause of death to be mixed drug toxicity (cocaine and ethanol), with the manner of death ruled as an accident.

The Internal Affairs Force Division did not initiate an investigation into the case, as the officers did not apply any force. The Multi-Agency Taskforce (MATF) took on the primary responsibility for the investigation, while the Internal Affairs Professional Standards (IAPS) performed an administrative review of the incident.

Case Review:

Computer-Aided Dispatch Reports
APD Field Reports
Internal Affairs Reports

On-Body Recording Device Videos
MATF Investigation
IAPS Investigation
Office of Medical Investigator Report

Involved Officers:

- Sergeant (1)
- Officer (2)
- Officer (3)
- Officer (4)
- Officer (5)
- Officer (6)
- Officer (7)
- Officer (8)

Policy Consideration and Outcome:

The applicable policies that Internal Affairs Professional Standards investigated for all involved officers are:

SOP 1-62-8.E.1.b Internal Affairs Professional Standards (IAPS) Division
8. Investigations Procedures
E. IAPS Division Call-Out Procedures
1. The ECC shall call-out the on-call IAPS Division Investigator/Detective under any of the following circumstances:
b. In custody deaths;

This policy provision was investigated for all involved officers on the scene. The investigation determined, based on clear and convincing evidence, that the alleged misconduct did not occur or did not involve the subject officers.

SOP 3-41-4.B.3 Complaints Involving Department Personnel
4. Procedures
B. Complaints
3. Department personnel who have, or reasonably should have, knowledge of potential policy violations (s) shall complete an Internal Affairs Request (IAR) through the IA database web application no later than twenty-four (24) hours after obtaining the knowledge.

This policy provision was investigated concerning the Sergeant, who was notified by the primary officer during the on-scene investigation that the OBRD was not activated for a portion of the initial interaction with the individual. Initially, it seemed that the Sergeant had not submitted a report regarding this violation. However, upon further review, it was established that the Sergeant submitted the report within the requisite timelines. The investigation concluded, based on clear and convincing evidence, that the alleged misconduct did not occur or did not involve the subject officer.

SOP 2-8-5.B Use of On-Body Recording Devices
5. Mandatory Recording
B. For all mandatory recording events, Department personnel shall activate their OBRD prior

to contact with individuals, except during emergency situations that require immediate action to preserve life or safety. At the first available opportunity, Department personnel shall activate their OBRD immediately.

The investigation determined that the initial responding officer failed to activate their OBRD as they exited the vehicle and ran after the individual. As the officer became aware, they turned on their OBRD. The investigation determines, by a preponderance of the evidence, that the alleged misconduct did occur.

Findings:
The CPOA and CPOAB agreed with APD's determination in this case.

Additional Policy and Training Considerations:
The CPOAB raised concerns pertaining to the response time for rescues and is currently in the process of reviewing the policy regarding officers initiating rescue calls. Furthermore, the investigation conducted by the Internal Affairs Professional Standards (IAPS) revealed no additional policy violations or further training considerations that require attention.

No additional recommendations were proposed.

The Civilian Police Oversight Advisory Board reviewed this case at its November 14th,2024 meeting. The Board's discussion can be found in the November minutes here: cabq.gov/cpoa