IN THE CIRCUIT COURT OF JACKSON COUNTY, MISSOURI
AT

POLICE NO. :	2023-01974
PROSECUTOR NO. :	095478013
OCN:	

STATE OF MISSOURI,)
PLAINTIFF,)
vs.)
)
RACHEL R ATHERTON)
200 Main St) **CASE NO. 2416-CR**
Boonville, MO 65233) **DIVISION**
DOB: [redacted])
Race/Sex: W/F)
S.S.N.: [redacted])
DEFENDANT.)

COMPLAINT
WARRANT REQUESTED

Count II. Involuntary Manslaughter 1st Degree (565.024-001Y20200999.0)

The Prosecuting Attorney of the County of Jackson, State of Missouri, upon information and belief, charges that the defendant, in violation of Section 565.024, RSMo, committed the class C felony of involuntary manslaughter in the first degree, punishable upon conviction under Sections 558.002 and 558.011, RSMo, in that October 26, 2023, in the County of Cooper, State of Missouri, the defendant, an employee of the Cooper County Sheriff's department, recklessly caused the death of Brooke L. Bailey, an individual in the custody of the Cooper County jail, by failing to procure necessary medical attention for Brooke L. Bailey and by discouraging other employees of the Cooper County Sheriff's Department from procuring such medical attention for Brook L. Bailey.

The range punishment for a class C felony is imprisonment in the custody of the Missouri Department of Corrections for a term of years not less than three (3) years and not to exceed ten (10) years; or by a fine not to exceed ten thousand dollars ($10,000); or by both imprisonment and a fine. If money or property has been gained through the commission of the crime, any fine imposed may be not more than double the amount of the offender's gain from the commission of the crime.

The facts that form the basis for this information and belief are contained in the statement(s) of facts filed contemporaneously herewith, made a part hereof, and submitted as a basis upon which this court may find the existence of probable cause.

Wherefore, the Prosecuting Attorney prays that an arrest warrant be issued as provided by law.

JEAN PETERS BAKER
Prosecuting Attorney
Jackson County, Missouri
by,

/s/ P. Benjamin Cox
P. Benjamin Cox (#60757)
Assistant Prosecuting Attorney
415 E. 12th St., Fl 7M
Kansas City, MO 64106
(816) 881-3975
BCox@jacksongov.org

WITNESSES:

The State's witnesses as of 2/29/2024 are included on the "State's Witness List" filed contemporaneously with this Complaint.

IN THE CIRCUIT COURT OF COOPER COUNTY, MISSOURI

POLICE NO. :	2023-01974
PROSECUTOR NO. :	095477733
OCN:	

STATE OF MISSOURI,)
PLAINTIFF,)
vs.)
)
ROBYN L PFEIFFER)
200 Main Street) **CASE NO.**
Boonville, MO 65233) **DIVISION**
DOB: [redacted])
Race/Sex: W/F)
S.S.N.: [redacted])
DEFENDANT.)

COMPLAINT
WARRANT REQUESTED

Count I. Involuntary Manslaughter 1st Degree (565.024-001Y20200999.0)

The Special Prosecuting Attorney of the County of Cooper, State of Missouri, upon information and belief, charges that the defendant, in violation of Section 565.024, RSMo, committed the class C felony of involuntary manslaughter in the first degree, punishable upon conviction under Sections 558.002 and 558.011, RSMo, in that on or about October 26, 2023, in the County of Cooper, State of Missouri, the defendant, an employee of the Cooper County Sheriff's department, recklessly caused the death of Brooke L. Bailey, an individual in the custody of the Cooper County jail, by failing to procure necessary medical attention for Brooke L. Bailey and by discouraging other employees of the Cooper County Sheriff's Department from procuring such medical attention for Brook L. Bailey.

The range punishment for a class C felony is imprisonment in the custody of the Missouri Department of Corrections for a term of years not less than three (3) years and not to exceed ten (10) years; or by a fine not to exceed ten thousand dollars ($10,000); or by both imprisonment and a fine. If money or property has been gained through the commission of the crime, any fine imposed may be not

more than double the amount of the offender's gain from the commission of the crime.

The facts that form the basis for this information and belief are contained in the statement(s) of facts filed contemporaneously herewith, made a part hereof, and submitted as a basis upon which this court may find the existence of probable cause.

Wherefore, the Prosecuting Attorney prays that an arrest warrant be issued as provided by law.

JEAN PETERS BAKER
Prosecuting Attorney
Jackson County, Missouri
Special Prosecuting Attorney
Cooper County, Missouri
by,

/s/ P. Benjamin Cox
P. Benjamin Cox (#60757)
Assistant Special
Prosecuting Attorney
415 E. 12th St., 10th Floor
Kansas City, MO 64106
(816) 881-3975
BCox@jacksongov.org

WITNESSES:

The State's witnesses as of 2/29/2024 are included on the "State's Witness List" filed contemporaneously with this Complaint.

AMENDED STATEMENT OF PROBABLE CAUSE

PCSO Complaint: 2023-01974

Date: 02/28/2024

I, Sheriff [redacted], [redacted] County, Missouri, upon my oath, and under penalties of perjury, state as follows:

1. **I have probable cause to believe that on 10/27/2023, at 200 Main St, Boonville, Cooper County, MO, [redacted] committed one or more criminal offenses.**

2. **The facts supporting this belief are as follows:**

On 10/27/2023 at approximately 0807 hrs., [redacted] was dispatched to the Cooper County Jail, 200 Main St., Boonville, MO, reference a death investigation involving a detainee within the jail. Cooper County Sheriff [redacted] contacted me via cell phone and requested the Pettis County Sheriff's Office conduct the investigation. I agreed.

Upon arrival, [redacted] met with [redacted] who later remained alongside [redacted] for several interviews as Shikles was assigned to the internal investigative efforts relating to the in-custody death. [redacted] was led to the jail where the scene was processed (Holding Cell 1). Inside the cell, a female victim, identified as [redacted] 33 years-of-age at time of death, was lying supine (face up). [redacted] informed [redacted] was originally found prone (face down) and had been rolled over onto her back with the intent to perform CPR.

Upon entering the cell, [redacted] observed the floor to be "covered in urine and vomit". The vomit appeared to be "coffee ground emesis", or digested/partially digested blood, brown in color. A pool of emesis was observed next to [redacted] head, and said emesis was observed on her face. Continuing the investigation, [redacted] was rolled into a prone position, with the assistance of Cooper County Coroner [redacted], for photographs. Her shirt was lifted revealing lividity, which was photographed for evidentiary purposes. In addition to lividity, rigor mortis had set in resulting in a stiff body at the time of photography. Prior to body placement in a body bag, [redacted] performed a "D-Stick" check to evaluate blood sugar level. The test indicated blood sugar levels as "Hi", which was reported by [redacted] to be a measurement of blood sugar levels higher than the D-Stick instrument is capable of measuring.

Once [redacted] was removed from the cell, final scene investigation ensued. It was noted that the floor was littered with trash and food. A pair of overalls was located on the bottom bunk that were reportedly issued to [redacted]; she had removed them and lay on the floor after reporting to jail that she was hot. The overalls were stained with what appeared to be dried blood consistent with, assumed, dried blood located on [redacted] buttocks.

On 10/27/2023 and continuing several days, [redacted] and [redacted] conducted interviews with witnesses, involved parties, and witnesses. [redacted], a detainee housed in Holding Cell 1 leading up to and during Bailey's death, reported the following to [redacted]:

- [redacted] had reported to her that she believed she was dying on several occasions, and Hansen believed she was left dead in the cell for a long time.
- [redacted] stated that [redacted] communicated with jail staff on numerous occasions that she needed medical assistance due to an injury received exiting her assigned bunk.
- [redacted] advised that [redacted] was not moving at the time of "lights out" and reported this to jail staff, but they "did not listen". It should be noted that lights out at the Cooper County Jail is 2200 hrs.
- During breakfast meal pass, [redacted] stated she advised jail staff that [redacted] was not moving. This jail officer allegedly left a meal for [redacted] only, closed the "chuck hole", and left. At this time, [redacted] reportedly got on the intercom and reported to an officer in central control that [redacted] was not moving. After some time, she reported an officer responded and found [redacted] deceased. [redacted] was moved from the cell.
- [redacted] further advised that when [redacted] was able to be up on her feet, she communicated the need for medical attention to jail staff via the intercom numerous times, to no avail.
- [redacted] described her observations of deteriorating health. She stated [redacted] was complaining of abdominal pain, vomiting on herself, and urinating on herself. It was stated that eventually, [redacted] began hallucinating, she lay down on the floor, and never got back up.
- Hansen stated she believed jail staff "tormented" [redacted] and refused to help her.

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On 11/01/2023, an autopsy was performed at the Boone County Medical Examiner's Office. It was reported that no preliminary cause of death was identified.

On 11/01/2023, an interview with Cooper County Jail [redacted] was conducted; [redacted] were present. [redacted] advised that he had limited contact with [redacted] as the majority of it was during meal passes. He described a sickly demeanor about [redacted] after her return to Holding Cell 1, and he believed that this was due to withdrawal symptoms relating to ingestion of a controlled substance. He did advise that he had spoken to [redacted] mother on more than one occasion at which time he was advised and reminded that [redacted] is a diabetic and in need of special observation. [redacted] stated he entered this medical note into an alert tab for the remainder of jail staff to view and respond accordingly. He reported that "Staff…was concerned" about the alert, but [redacted] had advised in a "pass along" that neither [redacted] were to be taken to the hospital. This advisement was reportedly given the night before [redacted] died.

[redacted] reported that prior to [redacted] death, she was placed on "observation", which was intended to allow additional checks to monitor her more closely. He added that the night before her death, [redacted] had slept on the floor of the cell, and when he observed this on the day of her death, he did not think anything unusual was afoot. He reported that viewing the cell during the sequence leading up to her death, nothing notable was observed to include the inability to see any vomit or movement with [redacted] He recalled that [redacted] had spoken to him briefly about unrelated matters such as court and food service menu. Furthermore, he advised that he did not recall [redacted] report any type of distress via the intercom. He did describe the interaction on the morning [redacted] was found deceased. He advised that he delivered [redacted] breakfast to her at approximately 0730 hrs., at which time he did not see movement from [redacted]. He stated he reported this inactivity to jail staff, which prompted [redacted] to check on her at approximately 0800 hrs. It is at this time she was found to be deceased by jail staff. Upon learning of the death, [redacted] advised that he immediately retrieved medical equipment, but when he turned her over it was evident that she was, in fact, deceased, and life saving measures were futile.

On 11/01/2023, an interview was conducted with Cooper County Jail Sgt. [redacted]. [redacted] were present. [redacted] advised that he recalled the day [redacted] was booked into the jail and that she was moved from a holding cell into F Pod. He further advised that she was moved from F Pod back into Holding Cell 1 during his scheduled time off, and the movement and identification of [redacted] as being in Holding Cell 1, at that time, was questionable with staff. He advised that he physically checked with [redacted] to confirm her identification and relayed that to other jail staff.

[redacted] stated that on, what he believed was, October 26th, [redacted] was having problems, and he believed those problems were related to withdrawal symptoms. He advised that [redacted] was rolling around on the floor, but he was unsure as to what was causing the perceived distress. [redacted] physically checked on [redacted] when he observed her lying on her side. He advised she was moaning and groaning on the floor while reaching out with her hands drawing imaginary figures in the air. He stated he called a nurse after observing this and reading her medical alerts informing staff that she was a diabetic. He stated he was able to reach the nurse, noting that [redacted] advised him that he had already attempted to contact the nurse about [redacted] health but was unable to make contact.

The nurse, identified as, '[redacted]', reportedly advised that she believed [redacted] was withdrawing from Fentanyl upon hearing of her actions. [redacted] advised that he was told that she needed to see a doctor at that time. This medical instruction from the nurse was relayed to [redacted], and [redacted] stated that she stated, "No. [redacted] was not going to the doctor." During his interaction with [redacted], [redacted] noted that [redacted] was being observed by [redacted] via surveillance cameras. He noted that at this time, [redacted] was not moving, face down, and not making any noises. He said she was breathing and that was it. Any attempts at contact with [redacted] for the remainder of [redacted] shift resulted in no communication or response. [redacted] stated that he told the remainder of the staff to "keep an eye" on [redacted].

Upon his return to work on October 27th, [redacted] advised that he immediately checked on [redacted] via surveillance cameras. He recounted his observations as the following:

- Toilet paper near [redacted] buttocks.
- Vomit near [redacted] face, and that her face was in a pool of vomit.

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[redacted] stated he asked [redacted] when the last time anybody checked on [redacted], to which he reportedly replied, "around 0300". Sgt. [redacted] advised that Sgt. [redacted] was unable to report the last time any movement was observed. He (Sgt. [redacted] responded to the cell shortly thereafter upon hearing [redacted] was deceased.

Recalling his conversation with Lt. [redacted] discussing the nurse's orders to have [redacted] see a doctor, Lt. [redacted] allegedly responded that no medical treatment was needed because she believed [redacted] was "faking it". Sgt. [redacted] advised that he told Lt. [redacted] that [redacted] is a diabetic, to which she allegedly stated that [redacted] had not told her this. Lt. [redacted] further stated that since [redacted] had not complied with a finger prick to test blood sugar, or provide any other information, there was nothing to be done for [redacted] When describing [redacted] failure to display any movements, Sgt. [redacted] stated he suggested that [redacted] could be in a diabetic coma. He stated that Lt. [redacted] responded, "No, no, no". This conversation, as reported by Sgt. [redacted] was witnessed by Deputy [redacted] He noted that during this conversation, which he believed took place on October 26th at about 1530 hrs, both [redacted] and [redacted] were viewing [redacted] "rolling around on the floor." In retrospect, Sgt. [redacted] did recall speaking to [redacted] about whether or not anybody was going to get [redacted] some medical assistance, to which he replied the he is doing the best he can with what he has to work with. [redacted] further allegedly stated that jail staff was more concerned with getting a drug test administered on [redacted] than doing anything else. Sgt. [redacted] did note that several attempts were made to obtain a urinalysis from both [redacted] and [redacted] but attempts were unsuccessful.

Sgt. [redacted] continued his statement, recounting the events taking place after [redacted] death. After [redacted] death, Sgt. [redacted] stated that Lt. [redacted] instructed staff not to call anyone. He advised that Officer [redacted] had previously made a call to the nurse via his personal cell phone as opposed to a jail phone line because of this order. He then described the atmosphere within the jail after [redacted] death as "sad". He advised that Lt. [redacted] at one point, entered central control and told staff that [redacted] death was on [redacted] herself and nobody else. This was reportedly met with resistance by present staff, and statements were allegedly made by staff that "We" failed her and that [redacted] failed her by not providing medical assistance even when requested. Sgt. [redacted] advised that these statements were made by Officer [redacted] [redacted]

On 02/14/2024, a follow-up interview was conducted with Sgt. [redacted] Sgt. [redacted] informed Sgt. [redacted] that Captain [redacted] had been out of town on the day of [redacted] death, and that Lt. [redacted] was left in charge of the jail in his absence. He did advise, that on the day of [redacted] death, after discovery, he was involved in a text exchange with Lt. [redacted] During that exchange, he reported being told by Lt. [redacted] to make sure notes were included about the incident; Sgt. [redacted] advised that he was unsure what that meant. He stated he obtained the directive in which Lt. [redacted] allegedly stated that [redacted] was not to be taken to the hospital, and he turned it over to Detective [redacted]

Sgt. [redacted] informed Sgt. [redacted] that the jail had a policy and procedure manual for the jail, and it was located in the jail, but he did not know if those policies and procedures were followed as related to Bailey's death. He added that he believed there were things that could have been done in this case. Furthermore, he reiterated that he had previously spoken with the nurse who ultimately advised that [redacted] should be seen by a doctor. He again advised that he took this information to Lt. [redacted] that she should be seen by a doctor, but Lt. [redacted] allegedly stated that [redacted] had done this before, and the log didn't show that she was having any problems.

A review of the text messages between Sgt. [redacted] and Lt. [redacted] reveal the following (summarized):

- Sgt. [redacted] advised that it was hard to believe [redacted] did this to herself, prompting the response [redacted] could have told them about her diabetes. Lt. [redacted] advised that even though [redacted] mother told them of the diabetes, but [redacted] did not, she believed [redacted] had no plans to help herself.
- Lt. [redacted] referencing an alleged statement from Captain [redacted] stated Captain [redacted] said this was planned (believed to be referencing [redacted] plans). Sgt. Pace agreed.
- A text was sent to Lt. [redacted] in which Sgt. [redacted] advised he felt bad and responsible for what happened to [redacted] Lt. [redacted] advised that it was [redacted] fault and had chances to help them help her.

On 11/01/2023 an interview was conducted with Cooper County Jail Officer [redacted] Sgt. [redacted] and Det. [redacted] were present. Officer [redacted] advised that he did not have much contact with [redacted] during her stay in the jail. He advised that he passed out lunch to [redacted] on Wednesday the 25th, and at that time [redacted] took her lunch with no problems. However, on Thursday the 26th, he advised that he was passing lunch to [redacted] once again and at that time she was laying on the floor. He advised that he called her name once, with no response, and a second time, which prompted her to tilt her head but not respond verbally. He advised that he observed her breathing and moving, so he left her lunch at

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the cell which was received by [redacted]. Based on his previous experience, Officer [redacted] advised that he felt it was common for someone experiencing withdrawal to act in a similar fashion. He further stated that he continued to watch [redacted] on surveillance cameras throughout the day and at one point ran to the cell at approximately 1530 hrs., accompanied by Officer [redacted] and Deputy [redacted] when he thought he observed blood on her hand. He was later joined by [redacted] However, it was found not to be blood but hair in [redacted] hand. He reported continually checking on Bailey throughout the remainder of his shift by both surveillance camera and physical checks through the cell door window.

When Officer [redacted] returned to work on Friday, October 27th, he was called to "the floor immediately". He responded to Holding Cell 1 with Sgt. [redacted] and Officer [redacted] opened the door, and asked if anybody had contacted EMS to assist. He advised that he returned to central command and contacted EMS. He relayed to EMS that CPR was not being administered due to obvious death.

Officer [redacted] recounted the previous day, Thursday October 26th, and stated that Deputy [redacted] and Officer [redacted] had responded to Holding Cell 1 to obtain a urinalysis (UA) from [redacted] and [redacted]. A UA cup was left in the cell for [redacted]. Later, Deputy [redacted] returned to the cell, retrieved the empty cup, and returned to central control advising she was going to mark [redacted] down as a refusal to comply with the attempted UA. Officer [redacted] described his inability to understand how [redacted] was going to be marked as a refusal when she was not responsive or verbal. After passing lunch to [redacted] cell, he stated that he returned to Lt. [redacted] and Deputy [redacted] and informed them that they needed to do something, but he advised he was told by both Lt. [redacted] and Deputy [redacted] that there was nothing they could do and that [redacted] was "probably just faking it".

Officer [redacted] after [redacted] death, checked the pass on sheet from the 1600 to midnight shift, and on line 3 of that pass on it stated, "[redacted] and [redacted] are not going to the hospital per 470". The departmental serial number 470 is assigned to Lt. [redacted]. It should be noted that [redacted] is an unrelated male in an adjacent holding cell. Officer [redacted] stated that he did not know of any time when [redacted] condition was relayed to staff via the intercom by [redacted]. He also advised that [redacted] had not disclosed any medical conditions to jail staff, to his knowledge, and that the information pertaining to diabetes came from [redacted] family.

Recalling Thursday the 26th, Officer [redacted] stated that he had made two attempts to contact a nurse about [redacted] condition. He stated he called, with no answer, at 0852 hrs. and again at 1007 hrs. The second call was a successful connection with the nurse, and he relayed what he felt was pertinent information. After describing her condition and his belief that she may be experiencing withdrawal of detoxing, he asked if the nurse was going to be in on that day. He was advised that the nurse would not be in until November 1st. He advised that he expressed his desire to have [redacted] treated before the 1st, to which he stated he was told by the nurse that she was probably experiencing withdrawal and it would not affect her. He was not instructed to contact a doctor, so he did not do so. He then advised that the nurse ordered him not to call a doctor. Again, Officer [redacted] stated that on Thursday, after he spoke to the nurse, that Lt. [redacted] told him in person that they would not be sending Bailey to the hospital. When Sgt. [redacted] asked what it would take for an officer to contact EMS, he advised that it would be done if someone were not breathing or unresponsive. He determined, on Friday at the time Bailey was found not breathing, to make the call to the EMS. Again, he recalled that [redacted] was lying on her stomach taking deep, distraught breaths on Thursday at approximately 1530 hrs. He stated she would lift herself up and appeared to be trying to gag herself. He observed this on surveillance cameras, but advised that he did not call EMS as such a decision would have to be run through his superiors. He stated he did not want to "get his ass chewed" by doing so. He then described a previous observation of medical deterioration when [redacted] was acting dizzy, holding on to a wall, and then falling, striking her head on a wall at approximately 0730 hrs. on what he believed was Wednesday, October 25th.

On 11/01/2023, an interview was conducted with Cooper County Jail Sergeant [redacted] Sgt. [redacted] and Det. [redacted] were present. Sgt. [redacted] advised that he knew [redacted] was booked into the Cooper County Jail on a Monday after appearing in Judge Koffman's court, although he did not know the exact date. Bailey was initially placed in Holding Cell 1, and during that placement she asked Sgt. [redacted] about her bipolar medication. Sgt. [redacted] advised that the requested medication was later refused by the jail physician.

Sgt. [redacted] next interaction with [redacted] occurred on Wednesday, October 25th, when she had been moved from F Pod back to Holding Cell 1. He contacted Bailey in F Pod after he learned that she was continuously vomiting and using the restroom a lot. Sgt. Searles moved Bailey, at this time, back to Holding Cell 1, "so she could be watched on camera 24 hours per day". He described Bailey as hyperventilating and advised that he tried to calm her down. At this time, [redacted] informed Sgt. [redacted] that she was diabetic, but he advised to his knowledge, she was not as she had not reported it

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during intake nor was it listed in her file; all that was listed was she claimed to be suffering from bipolar disorder. Sgt. [redacted] stated he asked [redacted] to sign a release of information (ROI) form in an attempt to obtain her medical records, but she reportedly stated that she did not have enough energy to do so. He advised that he left the cell with the form, but she contacted him via intercom sometime after 1700 hrs. to report that she could not breathe. Sgt. [redacted] responded to Holding Cell 1 and described [redacted] to be crying, yelling, and stressed out. [redacted] advised that she had vomited, and in response Sgt. [redacted] stated he took her a mop bucket so she could clean up the vomit. She then stated that she had defecated in her pants, but he stated he did not see any evidence of that on the floor. [redacted] ultimately told him that she did not have enough energy to mop the floor.

Sgt. [redacted] advised that he attempted to get [redacted] to sign the ROI again, on which she reportedly "scribbled" on it. He stated he attempted to get more information about her doctor, meds, and pharmacy, but she refused to answer. Upon receiving the ROI with markings, Sgt. [redacted] advised that he recalled filling out a fax face sheet addressed to the Fulton State Hospital, but he then set the form and face sheet on a scanner and was unable to advise if he sent the form to its determined destination. After his departure from Holding Cell 1, Sgt. [redacted] reported seeing Bailey lay on a mat and covering up. He reported checking on her every now and then, but stated that he could see her stomach moving and she was breathing fine. Sgt. [redacted] advised this was the last interaction he had with [redacted]

Thursday, October 26th, was Sgt. [redacted] next shift. When he arrived, he stated that he observed [redacted] laying in the same position she was the night before when he last observed her. He stated that Lt. [redacted] told him that Bailey is fine, she had been moving, and they were watching her. When he asked Sgt. [redacted] if [redacted] had been taken to the hospital, Sgt. [redacted] stated that he told him that she did not need to go. He further stated that Sgt. [redacted] told him that they had not physically seen [redacted] but had only checked on her via surveillance camera. Sgt. [redacted] reported checking on [redacted] several times, again via surveillance cameras, and periodically by lifting the curtain covering the jail cell door. He reported that her stomach was moving and that he believed she was breathing. The last time he recalled checking on her was at 2349 hrs., Thursday the 26th. He advised that he informed Officer [redacted] [redacted] that [redacted] needed to be checked on every hour during cell checks prior to going home.

Sgt. [redacted] recalled speaking with [redacted] mother several times during which she would advise them that [redacted] was a diabetic. [redacted] mother advised that something needed to be done to help [redacted] but Sgt. [redacted] would not talk about her medical conditions citing the Health Insurance Portability and Accountability act (HIPAA). He advised that [redacted] never told him that she needed medical assistance via hospital or ambulance. Sgt. [redacted] also advised that he had spoken to Sgt. [redacted] who told him that he had spoken to the doctor who instructed [redacted] to be taken to the hospital. Sgt. [redacted] further stated that Lt. [redacted] had told him that [redacted] was faking it and did not need to see a doctor. Sgt. [redacted] then stated that on Friday, Officer [redacted] called the doctor or nurse and was instructed to take [redacted] to the hospital, but Lt. [redacted] said no.

Sgt. [redacted] stated that the day before this interview, October 31st, Lt. [redacted] told him that if she had been told that [redacted] needed to go to the hospital she would have done so. She allegedly stated that she wished people would not lie. Sgt. [redacted] added that he was the one who put in the 4 to midnight pass on that [redacted] was not to go to the hospital, per 470. He advised that Lt. [redacted] stated that [redacted] was only "puking and crapping herself" and they only need to keep an eye on it. He also advised that Lt. [redacted] was the one who instructed him to provide a mop and bucket for [redacted] to clean up the cell before another detainee was placed within.

On 11/01/2023, an interview was conducted with Cooper County Deputy [redacted] [redacted] Sgt. [redacted] and Det. [redacted] were present. Deputy [redacted] advised that she first contacted [redacted] while working as a bailiff in Judge [redacted] drug court. Deputy [redacted] stated that she was tasked with making an arrest of another individual, leaving Deputy [redacted] as acting bailiff. Deputy [redacted] was reportedly ordered by Judge [redacted] to take [redacted] into custody on a Department of Mental Health (DMH) commitment, and she was to be remanded in the jail until a bed was made available. Deputy [redacted] called Deputy [redacted] back to the courtroom as [redacted] was allegedly arguing with the judge and not following orders. Deputy [redacted] reported being in the courtroom as [redacted] argued with the judge for approximately 30 minutes before she was escorted to the Cooper County Jail where Deputy [redacted] completed the booking process.

During the booking process, [redacted] reportedly advised Deputy [redacted] of her medical conditions, which included bipolar, anxiety, and diabetes. [redacted] reported multiple prescription medications for bipolar and anxiety, but when asked for medications to treat diabetes, Bailey reportedly stated that she did not take any. Throughout the remainder of the booking process, Deputy [redacted] reported [redacted] to be argumentative and claim to be pregnant. When Deputy [redacted]

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told [redacted] that a urinalysis would need to be conducted for the pregnancy, [redacted] refused and stated that she had a "still birth" and the baby was "just dead inside her".

Deputy [redacted] reported that she worked in the jail an inordinate amount of time the week of [redacted] initial arrival at their facility. She described her arrival at the jail on Wednesday, October 25th, when she observed [redacted] lying on the floor in Holding Cell 1. She stated that Bailey had been moved back to Holding Cell 1 because she was forcing herself to "puke"; she stated she believed [redacted] was detoxing. When Deputy [redacted] returned to work on Thursday, October 26th, she reported seeing [redacted] again, lying on the floor. She stated that she still needed to obtain a UA on both [redacted] and [redacted] but when she responded to the cell she and [redacted] argued. She advised she was unable to obtain a UA on [redacted] and unable to obtain a UA on [redacted] because Bailey was lying on the floor moaning. She advised that she called out [redacted] name, but she did not respond; she reported [redacted] only moved a bit. Deputy [redacted] stated that, "she just left her alone".

On Thursday, October 26th, Deputy [redacted] stated she had Officer [redacted] call the nurse, [redacted] reference [redacted] medical condition. This call was allegedly placed on speaker phone for both Officer [redacted] and Deputy [redacted] to hear and communicate. Deputy [redacted] advised that she asked the nurse if she would be at the jail on that day, to which she reportedly replied that she would not be in until the following Wednesday. The nurse allegedly advised that there was something that could be prescribed for someone who was experiencing withdrawal symptoms relating to specific controlled substances, in response to a question Deputy [redacted] stated she asked, but that medication could not be prescribed over the phone. Deputy [redacted] advised she also asked if the nurse would be willing to collect UAs from both [redacted] and [redacted] when she arrived. This question was not addressed in the interview. However, Deputy [redacted] stated that she gave up on trying to get a UA from [redacted] and [redacted] they were obviously in active detoxification, and there was nothing they could do to help them because they would not tell them what substance(s) are related to the presumed detoxification. Prior to leaving the jail at the end of her shift, Deputy [redacted] reported checking on [redacted] via surveillance cameras and noted that her abdomen was moving and she was breathing.

When Deputy [redacted] arrived at work on Friday, October 27th, she reported seeing [redacted] in Holding Cell 1 via surveillance cameras. She noted that an ambulance had been dispatched to the jail and assumed that the ambulance was dispatched for [redacted] She stated she was able to deduce that [redacted] had passed when EMS entered the cell then walked back out.

Deputy [redacted] recounted a previous conversation with [redacted] mother, held on what she believed was Wednesday the 25th. During this conversation, [redacted] mother advised that [redacted] was a diabetic and asked Deputy [redacted] what was going on with her daughter. Deputy [redacted] stated that she would pass on the news about being a diabetic to her supervisor, but did not respond to any questions pertaining to any medical issues involving [redacted] mother advised that she believed [redacted] needed to go to the hospital, but Deputy [redacted] stated that she did not ask why the mother felt this way. Deputy [redacted] advised, during this interview, that she did not know what to believe and thought that [redacted] may just be experiencing "jail-itis". [redacted] mother reportedly stated that she wanted to speak with the jail administrator, but Deputy [redacted] allegedly told her that she would have to check with her supervisor before that could happen. When asked who her supervisor was, during this interview, she stated that she felt it would be Captain [redacted] but had also been told that her supervisor was Lt. [redacted] Deputy [redacted] advised that she took down the name and number of [redacted] mother to pass on to Lt. [redacted] Deputy Atherton further advised that she did not recall any order being issued that Bailey was not to be transported to the hospital or call the doctor. She advised that she did recall a conversation with the nurse who asked if Deputy [redacted] was able to obtain a blood sugar check from [redacted] but she stated she was uncomfortable doing so with force.

Deputy [redacted] continued by advising Sgt. [redacted] that she is not usually a jail employee and is unaware of medical procedures outlined in policy. She advised that she had to teach herself on how to deal with jail detainees and noted that she thought she may have overstepped her boundaries by having Officer [redacted] call the nurse. Deputy [redacted] further advised that she was unaware of any pass on procedures within the jail and that she would typically hear a verbal pass on. She claimed, however, that she would utilize a Word document to pass things on to other jail staff. Deputy [redacted] did recount a conversation held with Lt. [redacted] during which Lt. [redacted] expressed her belief that Bailey was "faking it" and they came to the conclusion that [redacted] was experiencing withdrawal but they did not know what substance was involved. Deputy [redacted] further advised that Lt. [redacted] asked her how [redacted] was any different from anyone else experiencing detoxification and that Lt. [redacted] did not want [redacted] to go to the hospital if all she was doing was experiencing detoxification.

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On 11/02/2023, an interview was conducted with Cooper County Jail Officer [redacted] Sgt. [redacted] and [redacted] were present. Officer [redacted] advised that on the Monday [redacted] was booked into the jail, he was told that she was in active withdrawal. He advised that he never spoke to her while she was in Holding Cell 1 even through meal pass and medical pass, but he noted that [redacted] did not receive any medication during said medical pass. Officer [redacted] further advised that during cell checks he performed, he noted that [redacted] was lying on the floor but was breathing. He noted that this was not an abnormal observation relating to his experience as it was not uncommon for someone experiencing withdrawal to lay on the floor.

Upon his return to work, Thursday, October 26th, he was advised to check on [redacted] once an hour as she was still experiencing withdrawal symptoms. He advised that he checked on her several times throughout the night, looking through the jail door window, and noted that [redacted] was lying face down on the floor but was breathing every time he checked. Officer [redacted] noted that he did not enter the cell to check on her physically. He added that throughout the duration of [redacted] incarceration, he never spoke to her personally. Regarding orders not to send [redacted] to the hospital and pass along, Officer [redacted] advised that he had not heard that [redacted] was not to be transported to the hospital; he described pass along as being verbal in nature at shift change from the outgoing shift to the incoming shift.

Reference medical observation and cell checks, Officer [redacted] advised that there was no log to track medical observations, but cell checks were tracked electronically by putting the checking officer's departmental serial number on the tracking mechanism. He added that he was not aware of [redacted] having any medical history, but restated that he was told she was experiencing withdrawal and may become sick. Officer [redacted] then advised that [redacted] was found deceased shortly after meal pass for breakfast by Officer [redacted] Officer [redacted] and Sgt. [redacted]

On 11/02/2023, an interview was conducted with Cooper County Jail Officer [redacted] Sgt. Cline and Detective [redacted] were present. Officer [redacted] advised that he is assigned to a day shift between the hours of 1600 and 0000, and he recalled [redacted] being booked into the jail on Monday. He claimed very little interaction between himself and [redacted] due to his assignment. On Thursday, October 26th, Officer [redacted] was assigned to an 0800 to 1600 shift, but left work between the hours of 0900 and 1000. Prior to leaving, Officer [redacted] stated he observed [redacted] via surveillance cameras and noted that she was lying on the floor of Holding Cell 1 in her underwear. He advised that he made the comment that she didn't look good, but Officer [redacted] said he thought someone would handle that after his departure. Officer [redacted] reported that Officers [redacted] Sgt. [redacted] and Deputies [redacted] and [redacted] were present when he made this comment, and his understanding was that [redacted] was experiencing detox from Fentanyl, specifically.

When Officer [redacted] returned to work on Friday, he reported hearing an argument between Sgt. [redacted] and Sgt. [redacted] concerning whether or not anybody had conducted a check of [redacted] well-being throughout the night. At this point, Officer [redacted] responded to Holding Cell 1 and found that [redacted] was dead. He was instructed to return to central command, to which he complied. Officer [redacted] then advised that while he did not know about any direct requests for medical attention from [redacted] Sgt. [redacted] Officer [redacted] Officer [redacted] and Deputy [redacted] all told him that the "higher ups" told them [redacted] didn't need to go to the hospital. When asked who "higher ups" are, Officer [redacted] stated, Lt. [redacted] and Deputy [redacted] However, he stated he did not hear this directive/order personally.

On 11/02/2023, an interview was conducted with Cooper County Jail Officer Shawn [redacted] Sgt. [redacted] and Detective [redacted] were present. Officer Beck advised that he recalled [redacted] being brought to jail on Monday, but advised he did not have any contact with her until Thursday, October 26th. When he arrived at the jail on Thursday, he advised he checked the surveillance cameras and observed a female in Holding Cell 1 with whom he was unfamiliar. Officer [redacted] stated that he was unable to determine identity through their jail tracker program, nor was anybody else in jail staff able to immediately identify her. He responded to Holding Cell 1 and made contact with [redacted] Officer [redacted] stated that he asked [redacted] who her cell mate was, to which she reportedly responded that she did not know. He then asked the detainee, which was later identified as [redacted] but her response was only a mumble.

Officer [redacted] advised that he conducted welfare checks on [redacted] for the remainder of his shift. He recounted behavior that he felt was odd, such as doing things with her hands. Officer [redacted] stated that at one point he asked [redacted] if she was OK, to which she mumbled, "yeah". By the end of Officer [redacted] shift, he reported seeing [redacted] lying on the floor between the toilet and concrete partition near the bunks. He stated it was obvious that she was breathing at this time.

Officer [redacted] returned to work on Friday, October 27th, and immediately checked the surveillance cameras. He noted that [redacted] was lying on the floor, in the same position she was in when he last observed her on Thursday, with toilet paper, "hanging out of her butt". He then asked Sgt. [redacted] when the last time anybody checked on [redacted] to which he reportedly replied, "about 3:00 am". Officer [redacted] continued saying Sgt. [redacted] told him that since Sgt. [redacted] only had two

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officers on duty in the jail, and one had to stay in control, they could not conduct in-cell checks. Officer [redacted] stated he immediately responded to Holding Cell 1, opened the door, and noted that [redacted] was not breathing and had discoloration in her hands (palms were blue). Officer [redacted] advised that [redacted] was with him at this time, and he immediately had Officer [redacted] remove [redacted] from the cell, cuff her to the nearby booking bench, and then return to central control. He then advised he radioed for Sgt. [redacted] to respond to Holding Cell 1, and he ordered whomever was in central control to call 911 and get EMS there immediately. Upon Sgt. [redacted] arrival, Officer [redacted] informed him that [redacted] was "gone" and "she's dead". He further advised that he was sure of [redacted] death as one of the officers rolled her over and it was evident. Officer [redacted] declared Holding Cell 1 a crime scene, ordered everyone out of the cell, and closed the door. He added that he attempted to contact Captain [redacted] to no avail, but he forgot that Captain [redacted] was out of town on that day.

After securing the scene, Officer [redacted] advised he returned to central command and retrieved a piece of paper to start a "chrono" log. He utilized this piece of paper to record times the cell door was opened, who entered, and when [redacted] was pronounced deceased. Officer [redacted] advised that he did not believe anyone entered Holding Cell 1 until the coroner arrived.

Officer [redacted] spoke with Detective [redacted] after securing the crime scene, and recounted events leading up to [redacted] death. He stated that on Thursday, October 26th, he observed [redacted] sitting up and doing things with her hands that he felt were odd. Officer [redacted] told Detective [redacted] that he responded to central control and spoke with Lt. [redacted] about his observations. He advised that he told Lt. [redacted] "I think we'd better get her out of here" and "she ain't right", in reference to [redacted] actions. Officer [redacted] stated that Lt. [redacted] responded by saying that [redacted] was just playing games. He then noted that he believed one of the officers had contacted the nurse reference [redacted] condition and actions, to which the nurse advised to get [redacted] out of the jail. However, according to Officer [redacted] Lt. [redacted] again stated [redacted] was playing games. Furthermore, Officer [redacted] advised that at this time, Thursday, October 26th, Lt. [redacted] and Deputy [redacted] were "whispering back and forth and giggling with each other".

Upon the removal of Bailey's body from the scene, Officer [redacted] advised that he responded to central command, where he saw Lt. [redacted] Lt. [redacted] was reportedly telling everyone in central command that "they had done everything they could". Officer [redacted] described his response in that he, "flipped the fuck out". He advised he looked at Lt. [redacted] and called her, "a lying bitch". He stated he reminded Lt. [redacted] that he had told her [redacted] needed an ambulance, but she responded, No", and that [redacted] was "just playing games". Officer [redacted] then advised that he told Lt. [redacted] "her ass was going to fry for this one", and he "wasn't going to lie" for her. In response to Officer [redacted] statements, he advised that he was sent home. Officer [redacted] further advised that while he accepted responsibility for his statements to Lt. [redacted] mistakes like that need to be owned. He recounted that jail staff had just been through medical training two months prior, and if they did not do their jobs it is called deliberate indifference. Officer [redacted] then stated that he felt Lt. [redacted] was negligent and he felt that she was influenced by Deputy [redacted] in Deputy Atherton saying [redacted] was playing games. Officer Beck then informed Sgt. [redacted] of a text conversation he had with Captain [redacted] during which it was suggested by Captain [redacted] that [redacted] was responsible for her own death, and staff was not to blame.

Officer [redacted] the recounted the events following [redacted] death. He advised that he was worried about things "disappearing", and he wanted to get it preserved. Officer [redacted] stated that after [redacted] death, Lt. [redacted] ordered Sgt. Pace and the rest of jail staff to enter notes into [redacted] jail tracker. Officer [redacted] advised that he told Sgt. [redacted] not to do this, that it was intended to "cover shit up". However, he stated that Officer [redacted] followed those orders and entered notes. Officer Beck then explained that rules in the jail change daily, depending on "which way the wind shifts". He further advised that he felt as long as he stayed within policy, he was doing right. However, he advised that policy was not being enforced.

Officer [redacted] reported that his last interaction with [redacted] involved her breathing and was unresponsive, she was not answering his questions. He further reported that he felt as if the surveillance cameras were used as a crutch, which resulted in difficulty in being able to tell if someone was breathing. Officer [redacted] then described a conversation he had with Sheriff [redacted] during which Officer [redacted] stated that he did not feel as if he had done everything he could have to provide medical treatment for [redacted] and that it was bothering him personally. He added that he was being subordinate in those actions. He further stated that on the morning of [redacted] death, or discovery thereof, he had completed two medical protocols for Hansen and another male detainee after he felt those detainees had been neglected for two days. He advised that was unaware of anybody ever running a medical protocol for [redacted] and that is what he was planning to do before he discovered her to be deceased. Lastly, he stated that he had never been trained on how to run the medical protocol at their jail, but he was familiar with a similar process from his time spent working for the Department of Corrections.

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On 11/02/2023, an interview was conducted with Cooper County Deputy [redacted] Sgt. [redacted] and Detective [redacted] were present. Deputy [redacted] stated that she first encountered [redacted] on Monday, October 23rd while in the courtroom. Deputy [redacted] advised that [redacted] was somewhat combative during court, which prompted her to call Deputy [redacted] to assist. Deputy [redacted] stated that when they neared the jail, Deputy [redacted] took custody of [redacted] and escorted her into the jail for booking. On Thursday, October 26th, Deputy [redacted] advised that she was in jail central control and noticed that the surveillance camera was monitoring Holding Cell 1 which showed a female subject, later identified by Deputy [redacted] to be [redacted] lying on her side. Deputy [redacted] stated that the cameras were not real clear, and she believed that she saw blood on [redacted] hands. Deputy [redacted] inquired with jail staff in central control if anyone had checked on her, but she was reportedly told that, "she was being watched on camera" and that Bailey was moving. Deputy Huntsperger continued, stating that up until this point she did not know that the female she [redacted] observing in Holding Cell 1 was [redacted] noting that she did not look anything like when she arrested her on Monday. Furthermore, Deputy [redacted] advised that she was concerned because it looked like [redacted] had "coughed up blood" on the floor near her head. During this observation, Lt. [redacted] was reportedly in central control and stated that it was not blood but Kool-Aid. Upon hearing this, Officer [redacted] reportedly stated that no Kool-Aid had been served on that day. Deputy [redacted] advised that she donned protective gloves at this point and went to Holding Cell 1, accompanied by Officers [redacted] and [redacted]

Upon entry into Holding Cell 1, Deputy [redacted] stated that Officer [redacted] asked [redacted] if she was doing OK, hailing her by her name. [redacted] reportedly sat up a little bit and mumbled. Deputy [redacted] advised that she looked at [redacted] hands and noticed that what she thought was blood was actually hair. It should be noted that as they entered Holding Cell 1, Deputy [redacted] allegedly came into the scene. Deputy [redacted] advised that Deputy [redacted] told officers that she and Lt. Pfeiffer had been watching Bailey on surveillance cameras, she was fine, and she was "just faking it". Deputy [redacted] then reportedly told Deputy [redacted] and the other officers to, "let her be". Officers left Holding Cell 1 and returned to central control where, according to Deputy [redacted] Deputy [redacted] again stated that [redacted] was faking it.

On the morning of October 27, 2023, Deputy [redacted] advised that she received a call from Deputy [redacted] at approximately 0800 hrs. from Deputy [redacted] Deputy [redacted] informed her that something bad had happened; Deputy [redacted] reported hearing sirens in the background. At approximately 0900 hrs., Deputy [redacted] arrived at court security and noticed that Deputy [redacted] had surveillance footage of Holding Cell 1 pulled up on the computer. Deputy [redacted] told her that officers were upset because they had been told not to take [redacted] to the hospital; Deputy [redacted] noted that she had not been part of that conversation and had not heard that. Deputy [redacted] also reportedly advised that she had been told by other officers it had been ordered in a pass on log that [redacted] was not to be transported to the hospital, per Lt. [redacted] and then described the pass on log as a printed document that is kept in a folder in a sergeant's office. Deputy [redacted] according to Deputy [redacted] further advised that she noticed [redacted] was chewing on something during the booking process and did not make her spit it out, which she then stated that she was also concerned that she missed something during the booking process resulting the [redacted] death.

Lastly, Deputy [redacted] discussed the atmosphere and comments made after [redacted] death. While in court security, Lt. [redacted] told Deputy [redacted] that she believed [redacted] had been faking it. Lt. [redacted] then reportedly made the comment, "At least we don't have to worry about her mom calling all the time now". Deputy [redacted] stated that she thought it was too early for humor like that and noted that Lt. Pfeiffer was giggling about it and how inappropriate that was. Reference Bailey's medical condition, Deputy Huntsperger [redacted] that she did not believe [redacted] was any shape to be in a cell; this was in reference to Deputy [redacted] Thursday observations of [redacted]

On 11/02/2023, an interview as conducted with Cooper County Jail Lt. [redacted] Sgt. [redacted] and Detective [redacted] were present. Lt. [redacted] recounted the booking process for [redacted] and noted that it was a DMH hold. As such, she advised that detainees are held in a holding cell for the purpose of observation and notation of any withdrawal symptoms for 24-48 hours. [redacted] was reportedly held in a holding cell for 48 hours and moved back to general population on Wednesday, October 25th and Lt. [redacted] noted that she was off that day.

Lt. [redacted] advised that on Wednesday, October 25th, she received a call from "Sgt. [redacted] It should be noted that Sgt. [redacted] has been previously titled as Officer [redacted] in the supplemental reports. During the call, Sgt. [redacted] informed Lt. [redacted] that [redacted] had diarrhea and other detainees in the pod stated that [redacted] was forcing herself to "throw up". Lt. [redacted] advised that she believed this was commonly due to anxiety issues, so she instructed Sgt. [redacted] to move [redacted] from the pod into Holding Cell 1 and place her on a medical watch. Reference Lt. [redacted] explanation of a medical watch, the intent is to observe a detainee via surveillance cameras 24 hours day to allow officers to see if

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anything happened, noting that in this case they would be able to see if [redacted] was actually "puking" or making themselves throw up. Lt. [redacted] further stated that this allowed them to inspect the contents of the vomit to determine if it they are "actually puking" or if "they had just poured their cereal in the toilet". Furthermore, Lt. [redacted] advised that her determination of what a medical observation is as being what it meant to her as opposed as to what may be set in policy. Lt. [redacted] noted that there is no medical watch log entered into their system, and she also asked Sgt. [redacted] to obtain a signed medical release of information from [redacted] She added that she was informed that [redacted] either refused to sign the ROI or refused "to tell them where it was going". Due to not having a signed ROI, Lt. [redacted] stated that they were unable to obtain medical records or history, so she told Sgt. [redacted] to note in jail tracker that [redacted] had refused to sign and was being uncooperative in attempts to get her the help she needed. It should be noted that Detective [redacted] stated that he had signed or marked ROI in his possession, and it was being preserved. At this point, Lt. [redacted] advised that she believed if an ROI did not have an actual signature on it, many places would refuse it.

On Thursday, October 26th, Lt. [redacted] stated she did not go back to the jail until around noon, at which time she observed [redacted] lying on the floor in her underwear and tank top. Lt. [redacted] stated that Deputy [redacted] had told her the nurse was contacted and subsequently described symptoms of both fentanyl withdrawals and methamphetamine withdrawals; the former included running around and anger, and the latter included being sleepy and lethargic. Lt. [redacted] determined the symptoms to reflect lethargy, to which Deputy [redacted] agreed. She noted that the nurse told them to keep any eye on her, and Lt. [redacted] stated that is what they did. Lt. [redacted] noted that in her experience in dealing with withdrawal from a controlled substance, those suffering from withdrawal were seen laying in the same position as [redacted] "for a few days". She added that in those instances staff would check on the detainee suffering from withdrawal to make sure they are moving around and breathing, and that had been done with [redacted] Lt. [redacted] added that since [redacted] was uncooperative with their attempts at obtaining a UA and would not tell them what substance had a role in a potential withdrawal, there was nothing they could do but watch her and make sure she was OK. Lt. [redacted] stated that she left work Thursday between 1800 and 1830 hrs., and received a call Friday morning from Captain [redacted] informing her of [redacted] death.

Lt. [redacted] told Sgt. [redacted] and Detective [redacted] that nobody ever approached her and told her that Bailey needed medical attention or that she needed to go to the hospital. She further added that since she is not a medical professional, she is unable to determine if [redacted] was actually "detoxing", but noted that [redacted] was uncooperative. Lt. [redacted] advised that she believed [redacted] was detoxing based on her experience, but stated that she would do whatever she was told to do by medical staff. Reference the pass on log in which it was noted that [redacted] was not to be taken to the hospital per her order, Lt. [redacted] stated that was news to her. She stated that the log was entered on Thursday between 1600 and 0000 hrs., and the first time she ever saw the note was the day before this interview. Lt. [redacted] stated she asked Sgt. [redacted] about the pass on log, and he reportedly informed her that he had been informed by day shift that [redacted] was not to be taken to the hospital per Lt. [redacted] direction. Lt. [redacted] denied saying that.

Lt. [redacted] advised that she had not refused to send [redacted] to the hospital and would not have done so. She then stated that she gets mad when she has to take somebody to the hospital for "something stupid". Lt. [redacted] stated that she spoke with Deputy [redacted] after she and Officer [redacted] called the nurse, and she noted that withdrawal symptoms were discussed and they were told to watch her. She also added that she was aware of a phone call from [redacted] mother during which she reported [redacted] being a diabetic and a note was placed in jail tracker. However, Lt. [redacted] stated that since [redacted] would not sign the ROI, and since [redacted] did not bring any medication with her during booking, there was nothing they could do about it. Lt. [redacted] then recounted that [redacted] mother had called several times a day and had spoken to "nearly everyone on staff". She advised that these phone calls were usually accusatory towards staff, and that she stated, "if anything happens to my daughter, I'm suing the shit out of you guys". Lt. [redacted] then stated that she recalled speaking to [redacted] mother once when she called to check on [redacted] but she noted that the mother did not inform her of any medical problems. She then described the procedure if a detainee is booked into the jail and reports being diabetic, and added that anytime there is a medical emergency, any staff member can call 911 and then report the emergency to the doctor.

Reference a conversation held about Bailey "faking it", Lt. [redacted] advised that she did have that conversation with Deputy [redacted] she noted that she is not a medical professional. Lt. [redacted] stated that Deputy [redacted] has a tendency to "get worked up", and the conversation took place on a day where stress was high. She again noted that she did tell Deputy [redacted] that [redacted] was faking it, but stated that even though she said it, she couldn't really tell if she believed it. Lt. [redacted] again stated she was following the nurse's advice by watching [redacted] and again stated nobody told her that [redacted] needed to go to the hospital or be seen by a doctor. She then advised that, again, only heard about the pass on log entry stating [redacted] was not to be taken to the hospital under her authority and that Sgt. [redacted] entered this after hearing it from day shift. Aside from hearing that, she did not have any conversation with Sgt. [redacted] about specifics

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regarding this pass on log nor did Sgt. [redacted] have any conversations with her about it. Lt. [redacted] then added that Captain [redacted] had no involvement in any directive to not send [redacted] to the hospital. Furthermore, Lt. [redacted] added that she had a conversation with Deputy [redacted] during which Lt. [redacted] said, "90% of medical emergencies we see in this facility are people faking it." Lastly, she advised that, "I wouldn't put it past her", in reference to [redacted] faking it. She stated, "she was fine until she went into population and then she made herself throw up. To me, that looks like anxiety and she's trying to get herself out of jail."

On 11/13/2023, an interview was conducted with Cooper County Jail Captain [redacted] Sgt. [redacted] and Detective [redacted] were present. Captain [redacted] recounted the initial contact and booking of Bailey. He advised that he remembered seeing Bailey around the courthouse on Monday, prior to her arrest, and that she was acting "weird" and "flighty". He advised that during booking, however, [redacted] demeanor was "calm" and "nice". Captain [redacted] stated that [redacted] was booked by Deputy [redacted] who he stated was new to the booking process, and was aware that [redacted] had refused to answer several booking questions or sign several booking documents such as:

- Personal property summary
- Medical treatment
- Cost of medical treatment
- Admission sheet

Captain [redacted] advised that since [redacted] had not cooperated with booking, he wanted to get a UA. He advised this was something he was trying formulate into policy due the number of detainees being booked into the jail experiencing detox. Captain [redacted] reported that [redacted] had refused the UA, but he did not remember anything else relating to her on that day, Tuesday, October 24th.

Upon his arrival back to work on Thursday, October 26th, Captain [redacted] reported learning that [redacted] had been moved out of a pod and placed into Holding Cell 1 due to her vomiting. He advised that they were trying to ascertain if [redacted] was "truthfully puking" as nobody had seen her get sick or exhibit any other issues. Captain [redacted] was also informed that staff did not have any medical information on [redacted] other than she had been booked with one medication that had been denied by the jail physician. He also stated he was informed that [redacted] mother had called to report [redacted] as a diabetic; he advised that he thought Lt. [redacted] may have been aware of this. Captain [redacted] then asked staff if a nurse had seen [redacted] but he was informed that the nurse would not be available until the next week. He advised that during his lunch break, Officer [redacted] informed him that [redacted] had refused her lunch. When he asked to elaborate on that, he was told that [redacted] rolled over and didn't want her food. Captain [redacted] stated he left the jail at approximately 1500 hrs., and was scheduled to be off on Friday.

Captain [redacted] stated he received a call from Sheriff [redacted] on Friday reporting [redacted] death. He stated that he was not part of any conversations with Lt. [redacted] or other staff during which it was relayed that [redacted] needed to go to the hospital or see a doctor; he added that he knew there was a conversation with the nurse who advised that [redacted] was to be watched. Captain [redacted] discussed medical observation and noted that it is not a policy, but he had added cameras to the jail to make it easier to keep an eye on detainees for a variety of things, to include detainees that are sick or detoxing. He then added that jail staff are allowed to call 911 for medical emergencies at any time, but their contracted jail healthcare provider, Advanced Correctional Healthcare, prefer to be contacted first so a doctor or nurse can be consulted. At one point in time, Captain [redacted] advised, there were "post orders" that directed staff to take certain actions during medical emergencies, but in an effort to clean up the facility, those posts were removed. He then added that the Cooper County Jail does not have written policies on which employees are trained.

Captain [redacted] told Sgt. [redacted] that he recalled having a message to call [redacted] mother, but he did not call her nor did he remember ever speaking to her. He then stated that he was waiting for Sgt. [redacted] to ask him why [redacted] was laying on the floor for so long. He then stated that while he was at the jail Thursday, he observed [redacted] lying on the floor and that it was not uncommon for detainees to do that, particularly in Holding Cell 1. He advised that Holding Cell 1 gets hot, and they usually keep females in that cell because, "they typically won't strip completely naked in the cell". Captain [redacted] stated that [redacted] had not vomited while in Holding Cell 1, and he felt she was going through detox; he stated the would just have to see how it went from there. Deputy [redacted] according to Captain [redacted] told him that after speaking to the nurse she learned that symptoms may vary depending on the substance, and he felt that both [redacted] and [redacted] characterized both of those specific symptoms: one exhibiting withdrawal from Fentanyl and one exhibiting withdrawal from methamphetamine. The latter being [redacted]

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On 11/27/2023, an interview was conducted with Cooper County Jail Officer [redacted] Sgt. [redacted] conducted this interview via telephone at the Pettis County Sheriff's Office. It should be noted that Jessica has not returned to work at the Cooper County Jail since [redacted] death, and now reside outside the State of Missouri. [redacted] advised that she first encountered [redacted] during booking on Monday. She described [redacted] demeanor as "cheerful", "smiling", and "in good spirits". She left work shortly after and returned the next day. On Wednesday, she was advised that [redacted] was rude and difficult with Deputy [redacted] but advised she did not have any contact with [redacted] on this day.

[redacted] returned to work on Thursday, October 26th and found that [redacted] had been moved into Holding Cell 1. She advised that she was new and was following senior officers around to watch how they interact with detainees. [redacted] believes that Deputy [redacted] did not like that she was following officers, so she was sent to central control and informed that she was going to assist Deputy [redacted] with obtaining UAs from [redacted] and [redacted] While Deputy [redacted] and [redacted] were walking to Holding Cell 1, Deputy [redacted] reportedly told [redacted] that [redacted] is a "bitch", a "liar", and is faking being ill by making herself throw up. When Jessica made contact with [redacted] she described her as much different that her first interaction. She noted that [redacted] was unresponsive and breathing heavily. [redacted] advised that in relying on her past experience in the medical profession, it was clear that [redacted] was having trouble breathing. She stated that when she called [redacted] name, it appeared she was trying to respond but would only reach out with her hands towards a nearby wall. [redacted] stated that she continued to try and speak to [redacted] by calling her name, but she was "shut down" by Deputy [redacted] who informed her that [redacted] was refusing to cooperate with the UA sample. [redacted] advised that she did not think it was a refusal, but left the cell and followed Deputy [redacted] back to central control.

Upon returning to central control, [redacted] stated that she was telling other officers (her sergeant, whose name she could not recall – later determined to be Sgt. [redacted] - and Officer [redacted] that [redacted] had labored breathing and needed medical attention. She then noted that Deputy Atherton, again, "shut down" the conversation, saying that Bailey is "fine" and that she was "faking it", to which Jessica [redacted] that she believed [redacted] was not faking it. Further, [redacted] stated that Deputy [redacted] had the demeanor of, "what she says goes" while she was in central control. When Deputy [redacted] left the room, [redacted] asked the other two if she (Deputy [redacted] was their supervisor, to which they reportedly replied that she was not. She added that the other two officers advised her that Deputy [redacted] has "tried to take over" in the jail. [redacted] told them that despite what Deputy [redacted] said, [redacted] was in need of medical help and needed to see a doctor.

Upon hearing this, [redacted] stated that Officer [redacted] and Sgt. [redacted] called the nurse. [redacted] stated she heard the nurse tell them that [redacted] needed to go to the hospital. She advised that Sgt. [redacted] then went to speak to Lt. [redacted] to inform her of what the nurse had said. Upon his return, Sgt. [redacted] advised that Lt. [redacted] and Deputy [redacted] were actively watching [redacted] on the surveillance camera when he spoke to them, and they were laughing and making jokes about her medical condition. He further reportedly told her that Lt. [redacted] told him that [redacted] is fine, and that Lt. [redacted] refused to get her medical treatment. Jessica stated that this upset her, and when she left work she told Sgt. [redacted] again, that [redacted] needed medical help. He reportedly responded by saying the he already went to Lt. [redacted] and he could not do anything else. Furthermore, before [redacted] left, Deputy [redacted] returned to central control where Deputy [redacted] saw [redacted] roll over on the surveillance camera and said, "See, she is fine. Fucking cunt". [redacted] stated that it appeared Deputy [redacted] had something against [redacted] and that she didn't have a heart.

When [redacted] returned to work, Friday, October 27th, she reported walking towards the Sally Port with Officer [redacted] They attempted to gain entry twice, but after the second request all she heard was screaming over the radio. She advised that she and Officer [redacted] ran into the booking room and proceeded into the holding area. [redacted] observed Officer [redacted] on the floor with [redacted] and it was clear something was wrong. She reported that Officer [redacted] told staff to call an ambulance over the radio, and when she observed them, via surveillance camera, roll [redacted] over it was clear she was dead. [redacted] stated she knew this not only from her previous medical experience but the fact that rigor mortis had set in; she also noted what she saw as blood and vomit coming from [redacted] mouth.

After Officer [redacted] left the scene and entered central control, he informed [redacted] that the overnight shift informed him that they were short staffed and were not able to check on [redacted] nor did they have a female officer on duty during that shift. Officer [redacted] reportedly told Jessica that night shift personnel told him they had not checked on [redacted] since 2000 hrs. on Thursday, October 26th.

She stated that the officers in central control were informed that this was now a death investigation, and they all needed to remain on scene. [redacted] stated that she told officers that [redacted] death was due to negligence on their part. She advised that she told them that [redacted] suffered and she [redacted] told them [redacted] needed help the day before. [redacted]

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advised that the shift was quite sad, and she believed the death was Deputy [redacted] fault because she had been very "ugly" towards [redacted] had refused medical treatment, and appeared to have a vendetta against [redacted]

[redacted] stated that Lt. [redacted] entered central control around 0900 hrs. and asked everyone how they were doing. Lt. [redacted] then allegedly went on to say that there was nothing more they could do because [redacted] had refused a UA. [redacted] stated that this upset Officer [redacted] and he responded by saying that what Lt. [redacted] said is "bullshit". Officer [redacted] reportedly continued by telling Lt. [redacted] that [redacted] couldn't have refused as she was unable to speak. He further stated that Lt. [redacted] had sat there watching [redacted] while laughing at her saying she ([redacted] is "fucking lying". Officer [redacted] reportedly continued telling Lt. [redacted] that she had refused medical treatment for [redacted] and he was going to talk all about it during the investigation. [redacted] stated that Officer [redacted] then stormed out of central control to go help an inmate who was claiming he was having a heart attack. She then stated she told Sgt. [redacted] that she believed Deputy [redacted] was lying about [redacted] refusing a UA as she ([redacted] was standing right there when it occurred and advised that [redacted] was unable to speak. [redacted] left work shortly thereafter.

[redacted] explained that she could not handle the idea of Deputy [redacted] being in control, as she was told, so she left work and decided never to return to the Cooper County Jail. She advised she felt there was a lack of compassion on Deputy [redacted] part. [redacted] stated that this death was preventable.

On 12/19/2023, an interview was conducted with Nurse [redacted] who was the nurse referenced in the deteriorating medical condition calls of [redacted] This interview was conducted via telephone with Det. [redacted] advised that she was a temporary nurse for Cooper County until such time that an assigned nurse could be hired. She advised that on Thursday, prior to [redacted] death, she had received calls from jail staff reference [redacted] condition. [redacted] stated that she instructed the officers to do a "medical protocol", which to her means that Bailey was to be referred to a doctor. However, she is unsure if the staff understood that. When asked by jail staff if they could do a "sick call form" that would prompt [redacted] to be seen by [redacted] when she arrived the following week, [redacted] stated that would be fine depending on what was going on with [redacted] further advised that she was informed of [redacted] blood pressure at 130/90, and that staff believed she was under the influence of something. In response, [redacted] stated she informed staff that [redacted] may be having withdrawal or tired; she described staff's relayed perception as tired and lethargic reference Bailey, but stated that was the extent of what she was told. Furthermore, [redacted] advised that nobody called her after [redacted] death and that she had learned of it through her boss.

On 11/02/2023, Bailey's mother, [redacted] contacted Sgt. [redacted] and provided a log of her contacts with the Cooper County Jail. On October 25th, Stacey called three times: 1928 hrs., 1931 hrs., and 1940 hrs. The first call was reported to advise jail staff that [redacted] called her mom to tell her she could not breathe and felt as if she was dying. The second call reiterated the statement that [redacted] could not breathe, and [redacted] added that [redacted] is a Type I diabetic and needed her blood sugar checked. The third call, as reported by [redacted] was her begging jail staff to get a nurse and check her blood sugar. She advised she was told, "they will get ahold of someone". On October 26th, [redacted] reported that she called jail staff and asked that someone check on [redacted] to make sure she is OK, and then requested a return call from the captain. On October 27th, at approximately 1255 hrs., [redacted] called the jail and reported that staff told her that [redacted] was OK.

Surveillance footage from Holding Cell 1 was reviewed. This recording started on October 25th, 2023 at 1959 hrs. and ends on October 27th, 2023 at 1111 hrs. As noted in the video, the last time [redacted] was standing inside the cell was on Thursday, October 26th, at approximately 0700:46 hrs. At this time, [redacted] fell to the floor between the concrete barrier by the bunks and toilet, striking the back of her head on the lower bunk. She fell into the fetal position and remained approximately 0703:06 hrs. when she struggled to sit up. She was able to get to her knees, clearly disoriented at 0731:30 hrs. [redacted] moved on her knees to the wall near the bunk and continued to act disoriented (holding onto the window sill, moving her hands as if to feel around in the air). At 0732:29 hrs., [redacted] sits on her knees where she remains until 0738:02 when she adjusts off of her knees to sit on the floor. She continued to exhibit extreme disorientation. [redacted] continued to sit, propping her torso with hear arms. At one point, she held her right arm in front of her with her index finger bent towards her palm with her other fingers partially curled towards her palm at a lesser degree. At approximately 0744 hrs., the cell door opens and an officer leans into the cell. [redacted] was still positioned on the floor clearly disoriented; the door closed a few seconds later. At approximately 0746:05, [redacted] leans back and lays supine on the floor. At 0805:39 hrs., the cell door opens and a staff member enters briefly; Bailey is still laying on the floor, clearly disoriented. At 0806:27, [redacted] sits up, propping her torso up with her right arm. She is observed reaching out with her left arm towards the concrete barrier, but appears to be unable to focus; her arm is swaying similar to that of her torso. She sits up and reaches towards her bunk with her right arm and, again, towards the wall to her left. Jail staff is at the door observing this until the door closes at approximately 0808:12. [redacted] continues reaching towards the wall. Again the door opens and a staff member is seen standing at the doorway for less than a minute. The door closes again. At 0812:05,

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[redacted] lays down again. She remains on the floor in various positions until the time she was found deceased on October 27th at 0759 hrs. The last observable movement was on October 27th at approximately 0300 hrs., at which time [redacted] showed minimal movement in her torso. At 0302 hrs., a pool of vomit/brown emesis appeared near [redacted] mouth. At 0759 hrs., Officer [redacted] entered the cell and [redacted] is escorted out. At 0804 hrs., the cell is cleared and secured. Approximately 25 hours passed from the time [redacted] fell, never stoop up again, and the discovery of her death. During this time, observable labored breathing was clear on surveillance cameras.

On 02/28/2024, I received a final diagnoses of the remains of [redacted] This report was completed by [redacted] M.D. after a postmortem examination at the Boone/Callaway County Medical Examiner's Office on November 1, 2023. In the opinion of [redacted] Amaro, the cause of [redacted] death is diabetic ketoacidosis with hyponatremia.

Sheriff Brad Anders DSN# 600 /s/ S [redacted] #600

Print Name (Police Officer) **Signature (Police Officer)**

THE COURT FINDS PROBABLE CAUSE.

DATE **JUDGE**