IN THE MATTER OF AN ALLEGATION OF FAILING TO PROVIDE THE NECESSARIES OF LIFE IN HIGH PRAIRIE, ALBERTA ON AUGUST 3-6, 2018

DECISION OF THE ASSISTANT EXECUTIVE DIRECTOR OF THE ALBERTA SERIOUS INCIDENT RESPONSE TEAM

Assistant Executive Director:	**Matthew Block**
ASIRT File Number:	**2018-41(N)**
Date of Release:	**May 10, 2022**

Introduction

On August 8, 2018, pursuant to s. 46.1 of the *Police Act*, the Director of Law Enforcement assigned the Alberta Serious Incident Response Team (ASIRT) to investigate the hospitalization of the 38-year-old affected person (AP) after being in the custody of the Royal Canadian Mounted Police (RCMP) at the High Prairie Detachment. As a part of ASIRT's investigation, 6 officers were designated as subject officers, with notice provided to each. Our investigation is now complete.

ASIRT's Investigation

ASIRT's investigation was comprehensive and thorough, conducted using current investigative protocols, and in accordance with the principles of Major Case Management. ASIRT interviewed all relevant police and civilian witnesses, reviewed all relevant documentation, and obtained and analyzed all relevant video and audio recordings.

While under no obligation to do so, all six subject officers provided a statement to ASIRT investigators for use during the investigation. Evidence directly from the subject officers is often invaluable in cases such as this, as it can assist both with the factual determination of what occurred, and provide evidence of the subjective beliefs and perceptions of the subject officers.

Circumstances Surrounding the Incident

On August 3, 2018, at approximately 11:15 p.m., witness officer #1 (WO1), a RCMP High Prairie officer, was conducting an impaired driving investigation when he was alerted to an individual who was intoxicated and walking on the highway.

WO1 spoke to the pedestrian, who was the AP. The AP had outstanding warrants and was on conditions including a curfew of 11 p.m., so WO1 arrested him. Another officer, subject officer #1 (SO1) then took custody of the AP.

The AP was transported to the RCMP High Prairie Detachment by SO1. During this drive, the AP told SO1 that he was diabetic and asked for meal once they arrived at the detachment. SO1 replied "yeah sure, I can ask the guard to give you a meal." They arrived, and the AP was lodged into cells at 12:20 a.m. on August 4. As part of the prisoner

screening process, SO1 filled out a standard form called a C13. This form had information about identity and other topics on the front, and then some medical information on the back. On the back under "illnesses / Pre-existing Medical Condition," SO1 wrote "Type 2 Diabetic." Under "Medication type / dosage," SO1 wrote "Insulin + pills for insulin TBD." SO1 used "TBD" as an abbreviation for "to be determined." SO1 searched the AP at this stage as well, and found no medication on him. SO1 discussed the identity of the AP with his supervisor, subject officer #2 (SO2), because the AP had initially provided an alias. SO1 then left the C13 in the cell area, where it was accessible by guards and officers.

Over the weekend, the AP remained in custody at the detachment. Guards and officers could see him in his cell at all times on closed circuit television (CCTV), and both guards and officers also went to his cell to check on him and perform various tasks.

Saturday, August 4

On August 4, the log book used by officers and guards showed that the AP was checked at least every 15 minutes. The AP also interacted directly with guards or officers eight times and was provided four meals. At 4:37 p.m., subject officer #3 (SO3) checked on the AP and he replied with a thumbs up, as seen on the CCTV. At 9:13 p.m. on August 4, the AP was taken for a bail hearing by subject officer #4 (SO4). His hearing was adjourned and he was returned to his cell for a hearing on August 7.

Sunday, August 5

On August 5, the log book again showed that the AP was checked on by guards at least every 15 minutes. The AP also interacted with guards or officers four times and was provided three meals. At 4:38 p.m., SO3 checked on him and he again responded with a thumbs up.

Monday, August 6

August 6 was a holiday. On August 6, the log book again showed checks at least every 15 minutes. At 7:21 a.m., subject officer #5 (SO5) checked on the AP and received a thumbs up in response. The AP interacted with guards or officers six times before 7 p.m.

Around 7 p.m., a guard noticed that the AP was shaky and feeling unwell. The guard determined the AP had not received any medication for his diabetes and notified SO4,

who called Emergency Medical Services (EMS). EMS attended and measured the AP's blood sugar, which was high. EMS recommended that the AP be taken to a hospital. The AP was conscious and able to walk and converse, so he was transported to the hospital by SO4. He was admitted to the hospital.

The AP remained in hospital until August 8. Upon release, the AP was returned to High Prairie Detachment and then transferred to Peace River Correctional Center.

AP

The AP was interviewed by ASIRT investigators. He said that he told the guards and officers that he was diabetic. He told them exactly which medications he needed and that they could get them from a pharmacy nearby. At one point, a guard asked him if his medication had arrived yet. He mentioned that he needed his medication to a number of officers. He also mentioned his medication in his bail hearing.

The AP indicated that his diabetes gives him short term memory loss.

Cell Guards

All six cell guards who worked at the detachment from August 4 to 6 were interviewed by ASIRT investigators. They all described the AP as cooperative. None of them recalled hearing the AP ask for medication, and none of them made notes in the log book about such a request. No medication was ever in cells or provided to the AP. None of them noticed any changes or decline in health until the evening of August 6, when EMS was called. If someone did ask for medication, they would notify an officer. The officers would obtain the medication and the guards would dispense them as directed. One of the guards wrote "Diabetic ???" on an informal cheat sheet for the cells. This cheat sheet was used to assist guards and was not retained, but other guards recalled seeing the note.

SO1

SO1 was interviewed by ASIRT investigators. He heard the AP say that he is diabetic only once, while they were filling out the C13. He recalled the AP asking for a meal while being transported to the detachment, but not a mention of him being diabetic at that point. He thought that the vehicle noise and rain may have obscured some of the conversation.

SO1 did not email the next shift or speak to any supervisor about the unresolved medication issue. He expected that the guard or supervisor would arrange for medications to be obtained for the AP during the day shift. This was the first time this situation had arisen for him in his short career which was, at that point, approximately one year long. In the past when he was on day shift, he had picked up medications for prisoners from the night shift.

SO2

SO2 was interviewed by ASIRT investigators. He was the supervisor on duty in the evening of August 3 and into the morning of August 4. His only interaction with the AP was that he was present during a conversation between the AP and SO1. He also discussed the AP's identity with SO1, since the AP had initially provided an alias. SO2 did see the C13 but, since the conversation was about identity, he only looked at the front of the C13 where the identity information was. He did not look at the back of the C13 where the medical information was. SO1 did not specifically advise him of any medical concerns about the AP.

SO3

SO3 was interviewed by ASIRT investigators. He checked the AP on August 4 and 5. On both days, the AP gave him a thumbs up. At no time did the AP mention medication to him.

SO4

SO4 was interviewed by ASIRT investigators. He worked in the evening on August 4, 5, and 6. He recalled doing checks on the AP and getting a thumbs up in response. On August 4, he took the AP to a phone room and then for a bail hearing. At that time, the AP mentioned that he had insulin at home but that no one could bring it there. SO4 never noticed a decline in the AP until he was notified by the guard on August 6. He then transported him to the hospital.

SO5

SO5 was interviewed by ASIRT investigators. He checked on the AP at the beginning of his day shift on August 6. The AP gave him a thumbs up in reply. At no point did the AP mention anything about medication to SO5.

SO6

Subject officer #6 (SO6) was interviewed by ASIRT investigators. She worked the day shift on August 4, 5, and 6. On both August 4 and 5, SO6 and other officers on duty were called out early or at the beginning of their shift. On August 4, she did not check the AP and assumed another officer had done so. On August 5, she did not check the AP. On August 6, she was aware that SO5 checked the AP.

At no point did SO6 know that the AP required medication.

AP's Medical Records

With consent, ASIRT investigators reviewed the AP's medical records. After being in the emergency room, he was admitted on August 7 and discharged the next day. His diagnosis was diabetic ketoacidosis, which is a life-threatening complication of diabetes. It was caused, in this situation, by the AP not receiving insulin.

Policy

ASIRT investigators reviewed relevant RCMP policy, both at the national and detachment level. Policy required that an officer check each prisoner once per shift. In a day, there was a day shift and a night shift.

High Prairie Detachment written policy at this time stated that the senior officer on shift was the one responsible for checking prisoners once per shift. However, most interviewed officers said that the policy had been verbally changed at a detachment meeting to that the junior member on a shift was the one responsible.

Analysis

Police officers generally owe a duty of care to prisoners under their watch. Where a prisoner goes into medical distress while in custody, criminal liability may result where the officers failed to exercise reasonable care. Potential offences include failing to provide the necessaries of life and criminal negligence causing bodily harm.

Failing to provide the necessaries of life looks at whether there was a marked departure from the conduct of the reasonably prudent person. Necessaries of life can include many aspects such as medical attention. It must be objectively foreseeable that the failure to provide the necessaries of life would risk danger to the life or permanent endangerment of the health of the person. The standard is not one of perfection, and errors in judgment will not give rise to liability unless they reflect a marked departure from the relevant standard.

For the purposes of criminal negligence causing bodily harm, the following questions should be considered:

- Is there evidence that the acts or omissions of the involved officers showed a wanton or reckless disregard for the life or safety of the person?

- Is there evidence that the acts or omissions caused the bodily harm?

-and-

- Were the acts or omissions that caused the bodily harm a marked and substantial departure from the standard of care of the reasonably prudent officer in similar circumstances including what they knew or ought to have known?

The standard of care applicable to a police officer would be that of the reasonable officer in similar circumstances. An officer must live up to the accepted standards of professional conduct to the extent that it is reasonable to do so in the circumstances. The factors relevant to determining the reasonable officer standard include: the likelihood of known or foreseeable harm, the gravity of harm, the burden or cost which would be incurred to prevent the injury, external indicators of reasonable conduct, and statutory standards.[1]

The conduct of officers is to be measured against the standard of how a reasonable officer would act in similar circumstances. This standard must be applied while giving the appropriate recognition to the discretion that is inherent in police investigations and law

[1] *Hill v Hamilton-Wentworth (Regional Municipality) Police Services Board*, 2007 SCC 41, 2007 CarswellOnt 6265 at para 70; *Meady v Greyhound Canada Transportation Corp.*, 2015 ONCA 6, 2015 CarswellOnt 46 at para 67.

enforcement. The law does not require perfection, and officers are not guilty of an offence simply because matters could be done differently or better with different consequences. What is required is that police act reasonably.[2]

When an individual is brought into police custody, that person should be assessed to see if they need any medical treatment. This includes whether they will need any medical treatment while in custody, such as access to medication. Once that individual is in custody, regular wellness checks should occur so that any significant change in wellbeing is caught in a timely fashion.

Police officers are not medical professionals. While they may have more training in first aid and emergency medical responses than the average person, it must be remembered that they are police officers, not doctors or paramedics. As such, they must be alive to situations where it may be important to have a person in their custody medically assessed. Again, the standard is reasonableness and not perfection. Failure to recognize circumstances that might objectively give rise to a need to have a person examined could result in liability.

SO1

SO1 was a new officer with approximately one year of service. The AP was in the custody of SO1 once he was arrested, and it was SO1 who brought him back to the detachment and put him in cells. Other than some minor interaction with SO2, SO1 was the only officer dealing with the AP at this phase. SO1 was responsible for the initial assessment of the AP. It is clear that SO1 knew that the AP was diabetic and would need medication while in cells, since he indicated both on the C13 and to investigators. SO1 did not make any attempts to get medication for the AP at that time, which was reasonable since it was the middle of the night and no pharmacy would have been open. SO1 assumed that officers or guards on during the day would deal with the medication issue. In the past when SO1 was on day shift, he had dealt with similar issues left over from the night shift and had obtained medication for prisoners. He also did not send an email to the day shift about this issue, and instead decided that his notes on the C13 would be sufficient. SO1 did not work on the weekend after that shift ended.

[2] *Hill v Hamilton-Wentworth (Regional Municipality) Police Services Board*, 2007 CarswellOnt 665 (SCC) at para 3.

SO1 acted based on his past experience, which was limited. He believed the next day shift would see his notes on the C13 and deal with the medication. While it certainly would have been preferable for him to send an email to the day shift to ensure that they were aware of the medication issue, SO1's actions were not careless.

Looking at the potential charge of failing to provide the necessaries of life, it cannot be said SO1's conduct was a marked departure from the conduct of a reasonably prudent person. It was also not objectively foreseeable that the failure to take further steps to get the medication would risk danger to the life or permanent endangerment of the health of the AP.

The AP stated that he mentioned his condition and medication to many people during his time in custody. He did, at the very least, mention it to SO1 in the early morning of August 4 and to SO4 in the evening of August 4. However, the detachment CCTV shows that at each of the checks done by officers, the AP responded with a thumbs up indicating that he was fine. When action was finally taken to address the AP's declining health, it was initiated by a cell guard, not the AP. While it is true that the AP told at least two officers about his condition, the AP still did not take many opportunities to mention his medication to officers or guards. This does not mean that the AP was to blame, but his passivity affects the foreseeability of the situation for SO1. SO1 could not have foreseen that the officers and guards on subsequent shifts would not notice the medication issue and that the AP would not raise this issue continually until it was dealt with. As a result, there are no reasonable grounds to believe that SO1 failed to provide the necessaries of life.

Turning to criminal negligence causing bodily harm, the legal requirement is that SO1's omission show a wanton or reckless disregard for the life or safety of the AP. For the same reasons outlined above, that high standard is not met.

The remaining subject officers

The subject officers other than SO1 all had a lesser role in dealing with the AP. None of them showed a marked departure from the conduct of a reasonably prudent person, or wanton or reckless disregard for the life or safety of the AP.

SO2 was the supervisor of SO1 when he was bringing the AP into cells. He had a duty to ensure SO1 was performing his duties correctly. While more supervision of a new officer like SO1 would be preferable, this does not rise to the level of criminal liability.

SO3 and SO5 conducted checks and received thumbs up replies. There are no issues with their conduct.

The AP did mention his insulin to SO4. Similar to SO1, SO4 did not do anything about it due to the time of day and assumed the day shift would handle it. SO4 also should have taken further steps to ensure the AP got his medication, but this issue does not rise to the level of criminal liability.

SO6 was working on three day shifts, and the AP was only checked by an officer on one of those shifts. This again was poor work, but not to the level of criminal liability.

Overall Attention at the High Prairie Detachment to the AP's Medication

While there may not be reasonable grounds to think that any particular subject officer committed a criminal offence, this does not mean that the High Prairie Detachment did a good job in dealing with the AP. The AP entered custody with a common medical condition that would have caused no issue if he had been provided access to his medication. The AP told them about his medical condition.

The issues with how the AP was treated began with the detachment's policy. The written policy stated that senior officers were to check on prisoners. Most officers thought it had been changed verbally to that the junior officer was doing the checks. That was not universal, however, so there were some officers who thought that it was the senior officer who was responsible and others that thought it was the junior. This sets the stage for checks being missed.

After SO1 brought the AP into cells, he failed to pass along that someone needed to address the AP's medication the next day. His supervisor, SO2, should have recognized that SO1 was a new officer and supervised his work more so that this did not happen. Later that day, the AP also mentioned his medication to SO4, who again did not mention it to the following day shift.

For the next two day shifts, SO6 and other officers on duty failed to check the AP. Given that most officers seemed to think that the day shifts could get medication from a pharmacy for the AP, the failure of the day shifts to check on the AP is meaningful. While the AP may have just given a thumbs up like he did other times, a meaningful check with the AP during the day shift may have also led to the issue being discovered. During the entire time the AP was in cells, it appears that no officer bothered to check the C13.

Overall, the High Prairie Detachment failed the AP. These issues, being below the level of criminal liability, are for the RCMP to address.

Conclusion

The AP entered police custody on August 3 with a common medical condition that should have been easily addressed by the officers who dealt with him. Instead, due to the relative inaction of the subject officers, other officers, and the AP, he did not receive his required medication for almost three days.

While this was a failure of the High Prairie Detachment as a whole, the conduct of each individual subject officer does not rise to the level of criminal liability. There are no reasonable grounds to believe a criminal offence was committed.

Original signed by Assistant Executive Director	**May 10, 2022**
Matthew Block **Assistant Executive Director**	**Date of Release**