IN THE MATTER OF AN IN-CUSTODY DEATH IN EDMONTON ON MARCH 16, 2020

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

Assistant Executive Director:	**Matthew Block**
ASIRT File Number:	**2020-19(N)**
Date of Release:	**October 12, 2022**

Introduction

On March 16, 2020, pursuant to s. 46.1 of the *Police Act*, the Alberta Serious Incident Response Team (ASIRT) was directed to investigate a death that occurred in the Edmonton Police Service (EPS) detainee management unit (DMU). No officers were designated as subject officers. ASIRT's 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. Investigators interviewed all relevant police and civilian witnesses, and secured and analyzed all relevant video recordings. The cell where the incident occurred and adjacent parts of DMU were captured on video.

This incident involved community peace officers (CPOs), who are not police officers. Unless otherwise directed by the Director of Law Enforcement, ASIRT only investigates the actions of police officers. Since no special direction was given for this investigation, ASIRT's investigation was only of the involved police officers.

Circumstances Surrounding the Incident

At approximately 10:50 p.m. on March 15, 2020, the affected person (AP) was riding a bicycle on a sidewalk in Edmonton. Witness officers #1 and #2 (WO1 and WO2) stopped the AP and ran his name on police systems. The AP had several outstanding arrest warrants, and the officers arrested him. He was then taken to EPS DMU, searched, and processed. Before being placed in a cell at 11:44 p.m., he was assessed by a paramedic who found him to be alert and responsive with no injuries, and therefore fit for placement in cells. Throughout this process, the AP was cooperative. Once he was in cells, neither WO1 nor WO2 had further dealings with him.

The following day at 7:10 a.m., the civilian witness (CW) was placed in the same cell as the AP. The two talked and, at 7:42 a.m., CW dropped a white object on the bench in the cell. He then went to the cell door and appeared to be looking to see if anyone was outside of the cell. At 7:49 a.m., he returned to the bench, picked up the white object, and started doing something with it. He then moved his head down to the bench and from right to

left. CW got up, and the AP took his place. The AP also moved his head down to the bench briefly before getting up.

CW then laid down on the floor and appeared to go to sleep. The AP sat down on the bench. His movements were very deliberate and he appeared unsettled. He eventually laid down on the bench, facing the wall.

At 8:13 a.m., the AP appeared to spasm twice. He moved slightly in the next two minutes, but no further movement was noticeable on the cell video after 8:15 a.m.

Between 8:30 a.m. and 1:42 p.m., the video showed CPOs walking by the cells, including the cell the AP and CW were in. A CPO walked past the cell every ten minutes and would look into the cell as they passed by it. They did not stop and look into the cell for any significant amount of time, and never entered it other than the times described below.

At 12:14 p.m., CPO #1 (CPO1) came into the cell and placed food for both detainees next to them. The AP did not move.

At 1:29 p.m., a CPO came into the cell and pointed at CW, who got up and left with the CPO. The AP did not move.

At 1:37 p.m., CW returned to the cell. He checked on the AP, then moved away and stood by the cell door.

At 1:42 p.m., CPO #2 (CPO2) entered the cell and appeared to notice that something was wrong with the AP. He left, and CW picked up two objects from the floor. CPO2 returned with CPO1 and a paramedic. They began CPR on the AP, and naloxone was used. Emergency medical services was called, and CPR was continued until they arrived. Unfortunately, their efforts were unsuccessful and the AP was not resuscitated.

Autopsy

An autopsy was performed on the AP on March 17, 2020. The medical examiner determined that the cause of death was due to fentanyl toxicity. There was no evidence of injury that would explain death.

EPS Policy

EPS has policy on how detainees in DMU are to be checked. This policy states that walk-around physical checks must be completed every 15 minutes, and arousal checks must

be completed every hour. Arousal checks require that a detainee be awoken and spoken to in order to confirm that they are responsive and not in need of medical assistance. Arousal checks can be done with the CPO outside of the cell but, if the detainee does not respond, the CPO must enter the cell.

The CPOs

ASIRT investigators reviewed interviews that were conducted with three CPOs by EPS detectives as part of a related investigation.

CPO1 stated that the CPOs had been conducting the required arousal checks every 40 minutes that day. This check involved ensuring that the detainee was breathing. CPO1 had done a check prior to lunch and had paused at the door since the AP was in an odd position. The AP then made eye contact with him.

CPO2 stated he had done an arousal check at 12:40 p.m. and did not remember having any concerns.

Analysis

The video appears to show CW and the AP consuming drugs while in the cell. This is consistent with the cause of death of fentanyl toxicity given by the medical examiner. While the consumption of drugs was intentional, liability can still result for anyone responsible for the AP while he was detained.

Duty of Care to Detainees

Police officers and other officials generally owe a duty of care to detainees under their watch. Where a detainee goes into medical distress while in custody, criminal liability may result where the person in charge 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 persons 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 person 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 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

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

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.

Physical Searches

There is often a public perception that, when a person has been arrested and taken into custody, police have the authority to conduct a search of the person, including a strip search, before the person is lodged. That is incorrect.

Throughout the criminal justice process, a person has certain *Charter* rights that must be respected. Those rights are balanced against reasonable societal limits and, as such, what is permissible at some stages may not be permissible at other stages. For example, the authority to search a person shifts, as does the degree of search that might be permissible. What is clear is that the greater the degree of intrusion into the bodily integrity of a person, the greater restraint that must be exercised and the greater justification required to permit a search. A search will be reasonable within the meaning of the *Charter* where it is authorized by law, the law itself is reasonable, and the search is conducted in a reasonable manner.

There are a variety of levels of personal search, ranging from the less intrusive common "frisk" or "pat down" search, to a strip search, to the much more intrusive body cavity search. A strip search is defined as the removal or rearrangement of some or all of a person's clothing to permit a visual inspection of their private physical areas and/or undergarments.

It is recognized that strip searches involve a significant and very direct interference with personal privacy and are considered to be inherently humiliating and degrading. While there are circumstances where a strip search may be necessary, it is in this context that there are strict limitations as to when such a search will be permissible.

It is established law that reasonable grounds to make an arrest do not automatically convey the authority to carry out a strip search. Additional grounds relating to the purpose of the search are required. To meet the constitutional standard of reasonableness, the police must have reasonable and probable grounds justifying the strip search, in addition to having reasonable and probable grounds justifying the arrest. The mere possibility that a person under arrest may be concealing evidence or weapons upon his person is not sufficient justification for a strip search incidental to arrest. Strip searches cannot be carried out as a matter of routine policy applicable to all arrestees.

While a cursory frisk or pat down search is permissible, police may not conduct a strip search as a matter of practice or routine. The more intrusive the manner of search, the more restraint must be used. As such, in the absence of articulable grounds, police are not entitled to conduct a strip search. Sadly, this means that, on occasion, a person may be able to successfully maintain possession of controlled substances on their person when they are detained in custody. In this case, it appears that either CW or the AP was able to do so.

Actions of the Police Officers and the CPOs

After the AP was processed and lodged in a cell at DMU, the role of WO1 and WO2 ended. They have no responsibility for what followed.

While at DMU, the CPOs on duty were responsible for the AP. EPS policy, which applied to the CPOs, contains specific tasks designed to ensure the well-being of detainees. Here, the CPOs were required to conduct walk-around physical checks every 15 minutes and arousal checks hourly.

CPO1 and CPO2 told EPS detectives that they had conducted certain checks in the time leading up to the AP's death. Video from the cell showed that they had not actually done these checks. Further, the video showed that the CPOs on duty that day had not conducted a single arousal check on the AP between 8:30 a.m. and 1:42 p.m.

The CPOs on duty that day did not follow EPS policy, and then CPO1 and CPO2 appear to have tried to hide this. Since ASIRT's mandate does not extend to the CPOs, any further action regarding them is the responsibility of EPS.

Conclusion

After being arrested on March 15, 2020, the AP consumed drugs while in a cell at EPS DMU. He immediately seemed to be unsettled after doing so, and then laid down. He appeared to spasm shortly after that.

It is not clear whether the AP immediately went into medical distress at this time, or if he did in the following hours. This lack of clarity is due to the fact that the CPOs in DMU were not conducting the hourly arousal checks required by EPS policy. By the time someone had noticed that the AP was not well at 1:42 p.m., he could not be resuscitated.

No police officers were involved with the AP once he was in cells, and there are therefore no grounds to believe any police officer committed an offence. The actions of the CPOs are outside of the mandate of ASIRT.

Original signed	October 12, 2022
Matthew Block	**Date of Release**
Assistant Executive Director	