PRC Police Review Commission

ASIRT

ASIRT DECISION

IN THE MATTER OF A DEATH IN EDMONTON POLICE CELLS ON FEBRUARY 6, 2021

Acting Executive Director: Matthew Block

File No.: 2021-0009(N)

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Introduction

On February 6, 2021, pursuant to s. 46.1 of the *Police Act*, the Director of Law Enforcement directed the Alberta Serious Incident Response Team (ASIRT) to investigate the circumstances surrounding the death of a male individual, hereinafter referred to as the affected person (AP), while in the custody of the Edmonton Police Service (EPS). This investigation began prior to the establishment of the Police Review Commission on December 1, 2025, and associated changes to the *Police Act*.

No officers were designated as subject officers in this investigation and the ASIRT investigation is closed.

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 investigators interviewed nine police officers. They also reviewed the notes and reports of two additional police officers. Only six of the officers had any interaction with the AP, two of whom were limited to attending cells after the AP experienced medical distress.

ASIRT investigators reviewed all available video of the incident, including footage from inside the police detachment and the cell block. They also oversaw a scene examination conducted by EPS Crime Scenes Investigation Unit members.

ASIRT investigators also reviewed 911 and emergency medical services (EMS) calls and all relevant EPS radio transmissions from the incident.

ASIRT investigators also reviewed the cellblock log completed by the civilian guard, civilian witness #1 (CW1). CW1 chose not to participate in a voluntary interview.

Circumstances Surrounding the Incident

On February 5, 2021, at approximately 7:15 p.m., EPS officers were dispatched in response to a 911 call reporting a family fight at a residence and requesting police assistance in removing unwanted persons from the residence. Additional information was provided that a male was in possession of a sawed-off shotgun. A description of the male was provided, which in addition to information about ethnicity and age included reference to the fact that the male was wearing a bunch of chains.

Six witness officers (WO1, WO2, WO3, WO4, WO5, and WO6) responded to the area of the dispatch address. As police began arriving at approximately 7:29 p.m., the AP was observed walking in the residential complex. He matched the suspect description and was detained by WO1 and WO2. He provided his name to police but was otherwise verbally confrontational and argumentative and refused to follow police directions to keep his hands out of his pockets. Based on his behaviour, the AP was arrested for public intoxication and handcuffed without issue. He then advised police that he had a shotgun in his backpack, which had been placed on the ground. WO3 opened the backpack and observed a sawed-off shotgun with a shotgun round in the magazine as well as additional shotgun shells in a separate bag. It was later determined that the shotgun had previously been reported stolen, and that the AP was bound by a firearms prohibition. WO4, WO5, and WO6 did not have any interaction with the AP.

The AP was placed into a police vehicle, where he began striking his head against the window and slipped the handcuffs to the front of his body. Once he was re-handcuffed to the rear, he began

striking his head on the police vehicle's plexiglass partition and kicking the backseat of the vehicle. He was transported to the EPS Southeast Division and arrived at 7:48 p.m.

Video footage from Southeast Division captured the AP exiting the police vehicle and walking on his own into the detachment. The AP did not have any observable injuries. He was then searched and appeared to be cooperative and following all directions given to him. The AP was placed in the phone room at 8:01 p.m., and upon exiting at 8:13 p.m., he was lodged in a holding cell. Thereafter, the AP remained in this cell monitored by a civilian guard, CW1.

The AP eventually lay down on the ground of the cell, with his head leaned up against the cell door and his arms and feet crossed at 8:30 p.m. The AP never changed his body position or uncrossed his arms or legs at any point thereafter. However, at various points in the video, until approximately 3:05 a.m. on February 6, 2021, slight movements of the AP's right foot, arms, and stomach could be observed, and his chest could be seen rising and falling as though he was breathing.

At 5:55:54 a.m., WO7 and CW1 approached the AP's cell to provide him with a sandwich. As the cell door was opened, the AP's head, which was still resting on the cell door, was observed falling backwards. It then appeared as though someone began shaking the AP, without response. At 5:57:03 a.m., WO8 entered the cell and began chest compressions. EMS arrived at approximately 6:03 a.m. and continued life-saving efforts before eventually declaring the AP deceased.

While providing first aid to the AP, WO7 observed a small brown pebble lying beside the AP. It was seized and subsequently tested with a spectrometer and tested positive for carfentanil and methamphetamine.

The detainee log stipulates that detainees must be checked at 15-minute intervals alternating between visual and physical checks. The detainee log completed by CW1 relating to the AP recorded that physical checks via CCTV or visual checks of the AP at the cell door were conducted at 15-minute intervals as required; however, they did not alternate consistently. The detainee log was cross-referenced with what could be observed on the cell block footage and some inaccuracies in the log were noted with respect to the type of check recorded in the log, and the actual time visual checks were completed throughout the night. The video confirmed however, that CW1 conducted five visual checks of the AP between 5:24:23 a.m. and 5:54:05 a.m. and then proceeded to prepare a sandwich for him. There were no observable signs of any additional concerns or urgency on the part of CW1 to access the AP's cell prior to it being opened by WO7 to provide him a meal.

An autopsy of the AP was conducted by the Office of the Chief Medical Examiner (OCME) on February 9, 2021. Toxicology testing showed significant levels of carfentanil and methamphetamine in the AP's blood. The immediate cause of death was carfentanil and methamphetamine toxicity.

Analysis

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 or death.

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 risk permanent endangerment to the health, of the detainee. 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. Criminal negligence causing bodily harm or death applies a higher threshold and requires a marked and substantial departure from the conduct of a reasonably prudent person.

In this case, there is no evidence that this duty was breached.

At the time the AP was placed under lawful arrest, he was showing some signs of intoxication. There was no reported use of force beyond handcuffing at the time of his arrest. Once at the police detachment, he was ambulatory, presented as more cooperative as he followed police directions without issue, and was not observed to have any injuries.

No drugs or paraphernalia were found on his person when he was searched incident to arrest before being placed in cells. The subsequent discovery of a small quantity of carfentanil and methamphetamine beside the AP suggests that it had likely been concealed on his person.

Over the next approximately nine hours, the AP appeared to be fine. Although he lay in the same position throughout the night, there were no obvious signs that the AP was in any medical distress noted by CW1 or on the CCTV footage until CW1 and WO7 opened the AP's cell at 5:55:54 a.m. CW1 conducted regular physical and visual checks throughout the night. Although the checks did not appear to conform strictly to the requirements that they alternate between physical and visual checks at 15-minute intervals, the AP was under constant supervision. It is noted that more visual checks than what the requirements specifically dictate were conducted on the AP between 5:24 a.m. and 5:55 a.m., and CW1 did not appear to observe anything of concern.

As soon as the AP's medical distress was noted, CW1, WO7 and WO8 acted quickly and properly. They called EMS while providing the medical care that they were able to. There is no evidence of negligence or failing to provide the necessaries of life.

Conclusion

ASIRT was directed to investigate the death of the AP in the custody of the Edmonton Police. While untimely and tragic, there are no reasonable grounds to believe that any officers committed an offence.

Original Signed

Matthew Block

Acting Executive Director

December 17, 2025

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