

# ASIRT DECISION

**IN THE MATTER OF AN IN-CUSTODY DEATH IN  
LETHBRIDGE ON SEPTEMBER 2, 2023**

Acting Executive Director: Matthew Block

File No.: 2023-0033(S)

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## Introduction

On Sept. 2, 2023, 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 affected person's (AP) death in the Lethbridge Police Service (LPS) short-term holding facility (STHF) earlier that day. ASIRT designated one subject officer (the SO), with notice to him, and investigated a civilian employee (the subject of interest, SOI). 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.

ASIRT investigators interviewed the following civilians:

Civilian witness #1 (CW1), a registered nurse who treated the AP at the Chinook Regional Hospital (CRH);

Civilian witness #2 (CW2), a registered nurse who treated the AP at CRH;

Civilian witness #3 (CW3), a doctor who treated the AP at CRH; and

Civilian witness #4 (CW4), a paramedic working in LPS cells until 7 p.m., before the AP's condition worsened.

ASIRT investigators interviewed civilian witness #5 (CW5), a civilian employee of LPS working as a commissioner in STHF. The SOI, who was also a civilian employee of LPS working as a commissioner in STHF, did not agree to be interviewed by ASIRT. As the subject of a criminal investigation, this is her right.

ASIRT investigators interviewed the following community peace officers (CPOs):

Witness officer #1 (WO1), who worked in LPS STHF and dealt directly with the AP after she returned from CRH;

Witness officer #2 (WO2), who went to CRH with the AP and monitored her there;

Witness officer #3 (WO3), who worked in LPS STHF but left before the AP was found unconscious;

Witness officer #4 (WO4), who assisted police officers during the arrest of the AP;

Witness officer #5 (WO5), who monitored the AP at CRH; and

Witness officer #6 (WO6), who monitored the AP at CRH.

ASIRT investigators interviewed the following police officers:

Witness officer #7 (WO7), who was involved when the AP first came into LPS STHF;

Witness officer #8 (WO8), who searched the AP after she was arrested;

Witness officer #9 (WO9), who arrested the AP; and

Witness officer #10 (WO10), who transported the AP from CRH to LPS STHF.

The SO did not agree to be interviewed by ASIRT, as is his right as the subject of a criminal investigation.

ASIRT investigators also:

Obtained the AP's medical records;

Obtained video from CRH and LPS STHF;

Obtained police communications;

Obtained LPS information that showed when commissionaires signed into areas in LPS STHF;

Viewed the scene in LPS STHF;

Obtained the commissionaire logbook and check sheet; and

Obtained LPS policies relevant to the incident.

## Circumstances Surrounding the Incident

On Sept. 1, 2023, LPS officers arrested the AP for assault causing bodily harm after a stabbing. She was searched and a small amount of suspected drugs were found in a baggie in her hand. Officers took her to LPS STHF and she showed signs of an overdose including being extremely drowsy. Emergency medical services (EMS) attended LPS STHF at 12:38 a.m. on Sept. 2, and they brought the AP to CRH.

At the CRH emergency room, WO2, a CPO, saw the AP put yellow pills into her mouth. The pills were fentanyl, and hospital staff gave seven doses of Narcan to revive the AP.

At 4:35 p.m., CW3, a doctor at CRH, noted that the AP walked to the bathroom on her own and spoke with hospital staff. CW3 recommended her release from CRH.

WO10, a police officer, went to the CRH to pick up the AP. At that time, the AP was in a wheelchair and had been vomiting into a garbage can. WO10 asked CW3 to complete the prisoner form. The form stated she was treated for a "fentanyl OD," and, under medical treatment or medication administered, CW3 wrote "Narcan – large amounts."

The AP got back to LPS STHF at 5:29 p.m. She had difficulty responding to questions and needed help to stand. CW4, a paramedic at LPS STHF, took her vital signs before she was placed in a cell. The AP was standing on her own, vomiting into the toilet, and then lay on her side on the cell bench.

The SOI, a commissionaire, was working in LPS STHF and was responsible for completing physical checks of prisoners every 15 minutes. The SOI began her shift at 7:00 p.m. and completed some, but not all, of the required checks.

At 7:45 p.m., the SO, a supervising police officer, entered the cell and tried to wake the AP. After pushing her elbow and side with his foot and a clipboard, the SO wrote "refused to awake" and left. WO1, a CPO, was with the SO and said the AP appeared to be snoring. At 8:58 p.m., WO1 tried to wake the AP but could not find a pulse. The SO went to the cell and began CPR. EMS arrived and confirmed the AP was deceased.

## Witness Officer #1 (WO1)

ASIRT investigators interviewed WO1 on Sept. 3, 2023.

WO1 said he started working at LPS in February. On Sept. 2, officers brought the AP into the cell block and she sat on a bench for booking. She was unresponsive and they put her in a wheelchair. She began to show signs of an overdose, and they called an ambulance.

Her condition worsened. The paramedics assessed her and decided she needed to go to the hospital. At around 1:00 a.m., they took her to the hospital.

The AP remained at the hospital until about 5:30 p.m. WO1 had just returned to work for his shift at 5:00 p.m. He was told that she had overdosed again at the hospital and that she had fentanyl in her bra and had taken it there.

The AP was later returned to the station and booked in. She was not responsive and did not answer questions. WO1 said she may have been deliberately not providing information. She refused to give any information to members.

WO1 searched her belongings. Three CPOs placed her in a wheelchair and moved her to a cell. He did not see this but was told she had been vomiting and was placed on her side.

A paramedic assessed her when she returned to LPS. The paramedic said her vital signs were good but that she was very sleepy and unresponsive.

WO1 did not have contact with her until cell checks were done with the SO at about 7:30 or 7:45 p.m. He went into the cell and tried to speak to her. She did not respond, but she was breathing.

A commissionaire was conducting checks every 15 minutes to confirm she was breathing.

At 8:45 p.m., duty counsel called for her. WO1 entered the cell and tried to wake her. She did not respond. He observed what appeared to be slow breathing. He applied pressure points and pinched her back but got no response. He attempted to feel a pulse but could not find one. She was clammy and sweaty.

He called the SO. About a minute later, he called for an ambulance because her breathing was very spaced out and he could not find a pulse.

The SO arrived and WO1 told him he did not think she was doing well and that he had administered Narcan. They moved her to the floor and the SO started chest compressions. WO1 administered Narcan again and then took over compressions.

EMS arrived and continued compressions and treatment. Additional EMS and a fire truck attended. WO1 stepped aside but remained nearby and continued with other duties while observing.

WO1 believed that death was pronounced at about 9:42 p.m.

### *Witness Officer #2 (WO2)*

ASIRT investigators interviewed WO2 on Sept. 7, 2023.

On Sept. 2, WO2 followed an ambulance with the AP in it to the hospital.

They arrived at the hospital, and the paramedics unloaded the AP from the ambulance. WO2 observed that the AP was unconscious.

They went to the emergency triage area, and then a room. The AP said she did not want the paramedics to touch her and moved herself from the stretcher to the bed. WO2 said this was done slowly and with effort.

The AP refused assessment by both a nurse and the doctor.

At 2:08 a.m., WO2 was near the doorway of the room speaking with WO8. She heard the AP laugh and saw her place a yellow substance in her mouth and chew it. WO2 described a crunching sound. The AP

then dropped a plastic bag.

WO2 grabbed the AP's jaw to stop her from swallowing what she believed to be fentanyl. WO2 called out to the nurse. The nurse said they would monitor the AP for 20 minutes.

Later, the AP reached into her shirt toward her bra. WO2 held her hands to prevent this, and WO8 entered and assisted.

At 2:21 a.m., the AP became unconscious and stopped breathing. Several medical staff, including the doctor, entered the room. WO2 saw medical staff give multiple injections, believed to be Narcan.

At about 3:26 a.m., WO2 left the hospital and WO8 assumed continuity of the AP.

### *Civilian Witness #3 (CW3)*

ASIRT investigators interviewed CW3 on August 12, 2024.

CW3 was the CRH emergency room physician on Sept. 2. CW3 could not recall his exact shift on Sept. 2, but remembered the AP because he later learned of her death after discharge. During rounds later in her stay, she was drowsy but had not needed Narcan for several hours and appeared to be recovering. He turned off her oxygen and observed that her oxygen levels remained stable, which indicated improvement.

CW3 said he has extensive experience treating overdoses, including earlier work in emergency rooms in Vancouver.

CW3 recalled speaking with the AP when she went to the bathroom. He noted that when she walked to the bathroom, it was about 30 to 40 steps away in the hallway. She held her gown to cover herself and spoke to staff as she walked. He assessed that she was no longer drowsy or disoriented and was ready for discharge. He had nurses contact LPS and discharged her.

CW3 confirmed that the last dose of Narcan was given at 10:00 a.m. The AP was discharged at about 5:00 p.m. He confirmed these times using the patient chart.

CW3 said patients generally need about two hours after Narcan for it to clear their system.

He was told that earlier in the night, hospital staff had observed the AP taking something and that a substance believed to be fentanyl had been found and seized.

CW3 said that if a patient does not need more Narcan after two hours, the effects of Narcan have worn off. He said he allowed sufficient time after the last dose for the drugs to clear.

He stated that people who are committed to using drugs can be very resourceful.

When asked if anything could have changed the outcome, CW3 said that people may hide drugs on their body, including internally, and such searches require consent. He said it is very difficult to prevent this type of death. He said he has seen many similar deaths from drug overdoses and did not believe police would be able to prevent this unless someone was watching the person constantly.

### *LPS STHF Video*

ASIRT investigators obtained video from various cameras in LPS STHF. The videos showed the entire encounter, including the AP's return to cells.

At 12:16 a.m., the AP was brought into LPS STHF. She appeared unsteady on her feet and was placed in a wheelchair. EMS was called, arrived at 12:38 a.m., and transported her to CRH.

At 5:31 p.m., the AP returned to LPS STHF. She was slouched in a wheelchair and did not respond to questions. CW4 checked her vital signs while she was in the wheelchair.

At 5:38 p.m., the AP was placed in a cell. She was vomiting into the toilet and then lay on her side.

At 7:45 p.m., the SO entered the cell holding a clipboard. He used his foot to nudge the AP and then attempted to wake her using the clipboard. There was no visible response, and he left the cell.

At 8:58 p.m., WO1 entered the cell and attempted to wake the AP. When she did not wake, WO1 called for assistance.

The SO arrived at the cell at 9:03 p.m. and began CPR.

At 9:08 p.m., EMS arrived.

### *Check Sheet*

ASIRT investigators obtained the sheet where commissionaires record their 15-minute checks, and then compared that to the LPS STHF Video:

<b>Time</b>	<b>Code</b>	<b>LPS STHF Video</b>
19:00	Refused Meal	SOI physically checked the AP
19:13	Refused Meal	SOI is sitting at the commissionaire desk
19:15	Sleeping right side	SOI is sitting at the commissionaire desk
19:30	Sleeping right side	SOI physically checked the AP
19:45	Sleeping right side	The SO enters cell to check the AP
20:00	Sleeping right side	SOI is booking in a male prisoner at the booking desk
20:15	Sleeping right side	SOI is assisting a CPO with a male prisoner
20:30	Sleeping right side	SOI physically checked the AP
20:45	Sleeping right side	SOI physically checked the AP
20:58		WO1 enters cell and calls for assistance

## Commissionaire Logbook

LPS STHF had a logbook where the commissionaires would make entries. The following entries, in the order they were recorded, were relevant:

- 2100 hours – [the AP] found with low pulse and shallow breathing when [W01] went to receive her for duty counsel found not breathing
- 2105 hours – called EMS to cells
- 2045 hours – last 15 minute check, was breathing laying on her right
- 2109 hours - EMS arrived [W01] was performing CPR before EMS arrived NARCAN was administered.
- 2151 – decided to transport her to CRH because they feel a pulse.
- 2159 - EMS left, [the AP] has no pulse and is on the floor covered with a blanket in short term holding facility adult female holding corridor north.
- 0245 – ASIRT arrived, no scans only visual checks.

## Autopsy

A pathologist conducted an autopsy of the AP at the Office of the Chief Medical Examiner on Sept. 5, 2023. The pathologist reported the cause of death as acute p-fluorofentanyl (an analogue of fentanyl) intoxication. The pathologist found that the post-mortem p-fluorofentanyl level was higher than the hospital blood sample taken at 6:12 a.m. and stated that this was “compatible with repeated drug use following discharge from hospital.”

## 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 necessities of life and criminal negligence causing death.

Failing to provide the necessities 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 necessities 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 death, 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 death?

-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.<sup>1</sup>

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.<sup>2</sup>

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.

When the AP was first taken into custody, LPS staff correctly identified that her medical condition required the assistance of professionals. They called EMS, who then took her to CRH. She was at the hospital for over 15 hours. While there, medical staff treated her for overdose. She consumed more drugs, and they treated her for this. CW3, a medical doctor, determined that she was fit to be released. When the AP was returned to LPS STHF, she was assessed by CW4, a paramedic. She was sleepy and vomiting at times.

The SO and the SOI are not medical professionals. Their role was to identify situations that required medical attention. In this incident, that was a complex task. They were aware that the AP had been treated for an overdose, consumed again, and was treated again. They knew that a medical doctor had been in charge of her care for many hours and that a paramedic has assessed her on her return to LPS STHF. It was reasonable to expect that the AP be exhausted and sleep while in her cell.

The SO, the SOI, and other staff in LPS STHF were required to pay significant attention to the AP, given her medical state, and seek further medical assessment if her condition changed. The SO's check at 7:45 p.m., where he nudged her with his foot and clipboard and she did not wake, likely should have resulted in a check by a paramedic. There was no paramedic in LPS STHF at that time.

Similarly, some checks were missed by the SOI due to other tasks in LPS STHF. Given the AP's state,

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<sup>1</sup> *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.

<sup>2</sup> *Hill v Hamilton-Wentworth (Regional Municipality) Police Services Board*, 2007 CarswellOnt 665 (SCC) at para 3.

all checks should have been completed.

While these are deficiencies in the AP's care in LPS STHF, they were not marked departures. It is also not clear that they contributed in any way to the AP's death. As CW3 stated, it is very difficult to prevent this type of death. He did not believe police would have been able to prevent this unless someone was watching the person constantly.

## Conclusion

Based on the above, there are no reasonable grounds to believe that the SO, the SOI, or any other LPS staff committed a criminal offence.

The problem of where to hold intoxicated persons is a complex one. Often, police facilities end up holding such people by default after they are no longer suitable for a hospital. They would be safer in facilities specifically designed for intoxicated persons.

During ASIRT's investigation, LPS advised that there are now paramedics in LPS STHF 24 hours per day. In the absence of dedicated facilities, efforts to have more medical attention such as this are valuable.

*Original Signed*

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Matthew Block

Acting Executive Director

July 3, 2026

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Date of Release