PRC Police Review Commission

ASIRT

ASIRT DECISION

IN THE MATTER OF A DEATH OF A NEWBORN CHILD FOLLOWING DETENTION IN RCMP LLOYDMINSTER CELLS ON MAY 13, 2024

Acting Executive Director: Matthew Block

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Introduction

On May 14, 2024, 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 newborn child, while the mother, hereinafter referred to as the affected person (AP), was in the custody of the Kitscoty RCMP at the Lloydminster RCMP cells. This investigation began prior to the establishment of the Police Review Commission on December 1, 2025, and associated changes to the *Police Act*.

ASIRT designated five subject officers and provided them with notice. 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 or reviewed interviews conducted by the Saskatchewan Serious Incident Response Team of ten civilians.

ASIRT investigators interviewed 12 witness police officers.

ASIRT investigators reviewed all available video, including footage from inside the police detachment and the cell block and video from two police vehicles operated by the initial two arresting officers, subject officer #1 (SO1) and subject officer #2 (SO2). They also visited the scene and obtained photographs of the scene taken by RCMP Forensic Identification Section members.

ASIRT investigators also reviewed 911 and emergency medical services (EMS) calls, all relevant RCMP radio transmissions from the incident, and an audio recording of the AP's bail hearing on May 10, 2024.

ASIRT investigators also reviewed the cellblock log completed by the civilian guards, and other documentation and logs created by various officers relating to the AP's detention. They also reviewed a prisoner report relating to the AP's prior detention from January 5 – 8, 2024.

ASIRT investigators also reviewed the Lloydminster and Kitscoty RCMP detachment policies relating to prisoner care.

Circumstances Surrounding the Incident

On May 9, 2024, at approximately 6:30 p.m., the AP and her boyfriend, civilian witness #1 (CW1), were arrested at their residence. The AP was arrested for breaching an undertaking, outstanding warrants from Saskatchewan, and for obstruction as police had attended the residence earlier in the day looking for CW1 and she had provided a false name and date of birth to police. The AP was cooperative with the arrest, and no force was used by officers beyond handcuffing. At the time of her arrest, the AP told officers that she was pregnant. Initially, SO2 drove the AP to the Kitscoty RCMP detachment. When officers learned that Saskatchewan warrants out of Lloydminster would be executed, she was transported by SO1 to the Lloydminster detachment.

Upon arrival, SO1 completed the AP's booking, which included having a female civilian guard conduct a search of the AP and completing a prisoner report, form C-13, before placing her in a cell. SO1 only noted on the C-13 that the AP had indicated she took methadone. It was not noted that the AP had disclosed that she was pregnant. While at the booking desk, two civilian guards heard the AP tell SO1 that she was at least 36 weeks pregnant. When the AP began reporting a sore stomach later in the evening, those same guards advised the watch commander, subject officer #3 (SO3), that she may be pregnant before he went to check on her.

On May 10, 2024, at approximately 11:20 a.m., the AP threw a methamphetamine pipe out of her cell, which prompted a secondary search by witness officer #1 (WO1). During the search, the AP told WO1 that she was 36 weeks pregnant. WO1 relayed that information to at least the guard on duty and was advised that the AP had been providing inconsistent information in this regard.

At approximately 2:30 p.m., the AP was escorted by subject officer #4 (SO4) into a hearing room for the purpose of facilitating a bail hearing on her Saskatchewan warrants. After a Justice of the Peace determined that the AP would be held for at least six days, the AP grabbed the phone being used and in so doing, disconnected the call. SO4 grabbed onto her arm and placed his other hand on her back and directed her out of the room. She resisted and ended up on the ground. SO4 picked her up and escorted her back to her cell without further issue.

SO1 attended the AP's cell at approximately 5:30 p.m. and spoke to her about connecting her with the Virtual Opioid Dependency Program (VODP) to get her a prescription for the medications she needed. He had spoken with CW1 earlier that day who had reiterated the need for the AP to take the methadone as she had nearly lost the baby the last time she went through withdrawals without it. The AP subsequently spoke to a VODP nurse. Before going off-shift, SO1 arranged for SO2 to pick up any medications prescribed for the AP.

On May 11, 2024, at approximately 10 a.m., SO4 again escorted the AP into a hearing room for a judicial release hearing on her Saskatchewan charges. Her hearing was adjourned until May 13, 2024.

On May 12, 2024, witness officer #2 (WO2) followed up with SO1 about the AP's prescription. Further enquiries were made, which determined that VODP had sent the prescription to a pharmacy at the mall, but it had not been filled as the RCMP had an account at a different pharmacy. The prescription was then transferred to a different pharmacy, and it was filled and collected by WO2 in short order. WO2 then returned to the Lloydminster detachment and administered the first dose of medications to the AP. Two additional doses of medications were administered to the AP in accordance with the pharmacy's instructions.

At approximately 11:27 p.m., the AP began complaining about stomach pain and commented, "it's my baby." A guard noted that the AP appeared to be adopting a position that looked like she may be going into labour and began asking the AP questions to try to establish whether that was the case.

The AP denied that she had ever had a baby before or that she was in labour. The guard notified subject officer #5 (SO5), who attended the AP's cell and asked her if she was pregnant and experiencing contractions, but the AP would not confirm either. SO5 advised the guard to monitor the situation as she did not appear to require immediate medical attention.

At approximately 12:40 a.m. on May 13, 2024, the guards notified SO5 that the AP appeared to be experiencing a seizure, and the emergency alert button was activated. SO5 and two other officers, including witness officer #3 (WO3), attended the AP's cell, where the AP was observed to be experiencing an active seizure. She was placed in the recovery position until EMS arrived approximately five minutes later. When asked, the AP repeatedly denied being pregnant to EMS paramedics.

The AP was transported to the hospital and accompanied by WO3. The AP delivered her baby via emergency caesarean section. Sadly, her baby died approximately three hours later. The Saskatchewan Coroner's Officer determined that the child's death was natural and that the cause of death was cardio-respiratory arrest.

Throughout the AP's detention, the C-13 was never updated with any information relating to a possible pregnancy. It was also never added to any of the separately created watch commander reports, guard logbook, or the shift notes that officers created and disseminated to the officers coming onto the next shift.

On June 20, 2024, the AP was found deceased at her home. An autopsy of the AP was conducted by the Office of the Chief Medical Examiner (OCME). Based on the pathologist's report, the AP's death appeared to be unrelated to the time she spent in RCMP custody.

Affected Person (AP)

ASIRT reviewed an interview conducted by the Saskatchewan Serious Incident Response Team with the AP on May 15, 2024.

The AP confirmed that when she was arrested on outstanding warrants, she advised the officers that she was pregnant. She also reiterated to the officers that she was pregnant while being booked into the Lloydminster detachment. She denied ever saying otherwise and said it was the officers who were telling her that she was not pregnant. She noted that she had been arrested approximately two months prior and had told officers she was pregnant at that time as well.

The AP recalled an officer, believed to be SO1, contacting VODP on her behalf and arranging for her to receive suboxone. She confirmed that she was a daily user of fentanyl. She recalled being provided with two tablets on two separate occasions while in custody and that it made her feel funny.

The AP also recalled getting upset about being held in custody during a judicial interim release hearing and pushing the end call button on the phone to stop the call. After pushing the button, she recalled being thrown to the floor and then thrown in her cell by two male officers – one in uniform, who is believed to be SO4, and one in plain clothes.

The AP advised that she had a seizure in her cell and then woke up in the hospital. At the time of the interview, she was recovering from a caesarean section.

AP's Medical Records

The AP signed a consent to release her and her child's medical records from her hospital admission. Those records included a patient care report authored by EMS, which documented the AP denying that she was pregnant when asked several times by paramedics. They also confirmed that the AP was approximately 35 weeks pregnant, had severe gestational hypertension, and that she had experienced eclampsia seizures, including one while on the maternity ward. The records also disclosed a prior pregnancy that had resulted in a caesarean section delivery in 2018.

The AP delivered her baby by emergency caesarean section at approximately 5:53 a.m. The baby died at approximately 9:05 a.m. of cardio-respiratory arrest. Other conditions which were noted as contributing to the child's death were pregnancy-induced hypertension, maternal drug use, and intrauterine growth restriction.

Following the AP's death, CW1 provided his consent for ASIRT to obtain the AP's medical records relating to her dealings with VODP while in custody. The VODP records confirmed that the treatment providers were aware of the AP's pregnancy, her daily fentanyl use, a recent history of seizure, and her current withdrawal symptoms which she described as "10/10." VODP had faxed a prescription to her local pharmacy on May 10, 2024. A notation on the prescription itself indicated, "RCMP member notified of prescription, aware to contact VODP with any questions or concerns."

Subject Officers

As the subjects of a criminal investigation, the subject officers were entitled to rely on their right to silence and not speak to ASIRT. In this case, only SO2 submitted to an interview. However, each of the subject officers provided a prepared written statement. SO2, SO3, SO4 and SO5 also provided written responses to follow-up questions arising out of ASIRT's review of their written statements.

Subject Officer #1 (SO1)

SO1 reported that at the time of the AP's arrest on May 9, she advised that she was pregnant. SO1 suspected that she may be telling him that she was pregnant to avoid arrest, as from what he could see, she did not appear to be. Once at the Lloydminster detachment, while completing the C-13, the AP answered "no" when he asked her if she had any relevant medical or health conditions for them to know about. When asked about any prescription medications she took, the AP advised that she took methadone. SO1 noted that he told the guard on duty that the AP had said she was pregnant at the time of arrest but that she had not mentioned it again during the intake process.

The following day, SO1 met with CW1 to complete his fingerprinting. He asked whether the AP had any prescribed methadone at home and learned that she did not. CW1 told him that she gets her methadone at a particular pharmacy and that she should get some because the last time she went through withdrawals, she nearly lost the baby.

When SO1 attended the detachment later that day, he was advised by one of the guards that SO3 had checked on the AP overnight and that the AP had told him she was not pregnant.

SO1 then attended the AP's cell and spoke to her about her withdrawal symptoms, and she confirmed the same information as CW1 about where she ordinarily filled her prescriptions. SO1 made follow-up enquiries with the pharmacy and learned that the AP had not been prescribed any medications through their pharmacy since 2023.

SO1 then contacted VODP to set up a phone consultation for the AP to be able to access medication while in custody and facilitated a call between the VODP nurse and the AP. When a timeline for a subsequent call with a VODP doctor could not be specified, SO1 arranged with SO2 to pick up any prescription if and when it was prescribed. SO2 subsequently provided him with updates on the evening of May 10 and afternoon of May 11 that he had not been contacted regarding any prescription.

On May 12, WO2 contacted VODP and was advised that a prescription had previously been sent to a particular pharmacy. SO1 contacted that pharmacy and was told it should have been sent to another one who had an account for the RCMP, and they then transferred it there. WO2 then confirmed to SO1 that he had picked up the prescription and administered the first dose and provided the instructions for additional dosages to the officers at the Lloydminster detachment.

Subject Officer #2 (SO2)

SO2 confirmed that he had agreed to pick up a prescription for the AP if it was ready while he was on shift. He checked in with the guards at the Lloydminster detachment later in the evening and they told him that the medications weren't yet ready for pick up. He was not contacted or provided any further updates from the detachment in relation to the medication.

SO2's shift notes for May 10 indicated that he would touch base with the next Lloydminster RCMP shift officer on the morning of May 11 to arrange for the prescription to be picked up, but he confirmed that he did not do so. He sent text messages to SO1 on the evening of May 10 and the afternoon of May 11 advising him that he had not received any further updates about the prescription.

Subject Officer #3 (SO3)

SO3 recalled being present when SO1 was booking the AP into the Lloydminster detachment. When the AP was asked about any medical conditions or medications, she stated that she didn't have any.

Later that same evening, he was notified by a cell guard that the AP was complaining of a sore stomach and was advised that the AP may be pregnant. He noted that the C-13 did not reflect this. He attended the AP's cell and advised her that he had been told she may be pregnant and that her stomach was sore. She advised that she was going through withdrawals and did not acknowledge the possibility that she was pregnant. He offered to have her taken to the hospital and she declined, stating, "no, I'm fine." He was aware that SO1 intended to make calls to VODP, which he believed would address her withdrawal symptoms; therefore, he merely advised the guards to advise him if the AP expressed any further concerns or requested to go to the hospital. He indicated that he had no reason to believe she was anything but fine at the time.

SO3 noted that he did not update the C-13 with information about her pregnancy as the AP never told him that she was pregnant nor acknowledged that fact when he brought it up to her.

Subject Officer #4 (SO4)

SO4 facilitated a bail hearing for the AP on May 10. SO4 advised that at the conclusion of the hearing, after the six-day hold on the AP was granted, the AP became belligerent, stood up quickly, and violently grabbed the phone on the desk. To avoid the AP's behaviour from escalating, he grabbed the AP's arm with a c-clamp grip, and placed his other hand on her back to direct her out of the room. The AP resisted by applying all her body weight away from SO4, seemingly in an effort to break his grip on her arm, and she fell to the ground. He picked her up from the ground and began walking her back to the cell. Unbeknownst to him, a guard had pushed the emergency button, causing another officer to attend the cell block, but he was able to escort the AP back to her cell without further issue. The AP did not complain of any pain or request any medical attention after her fall. He also did not observe any visible injuries on the AP that would have warranted any medical attention.

The following day, he facilitated a Saskatchewan bail hearing for the AP. Based on her conduct the day prior, he applied handcuffs while moving her between her cell and the hearing room. The bail hearing

was adjourned. He recalled the AP disclosing to him that she was pregnant but reported being surprised by this as the AP had not mentioned it during her bail hearing and had only referenced having a doctor's appointment on the following Monday, which was the date her hearing had been adjourned to.

SO4 commented that it is not his practice or responsibility to review C-13s for completeness and that it is the job of the supervising member to ensure they are reviewed. He assumed that the processing officer and detachment staff had updated the C-13 and were aware of the pregnancy.

SO4 also administered the AP's last dosage of medication on May 12.

Subject Officer #5 (SO5)

SO5 was contacted by the guards on the evening of May 12 reporting that the AP was experiencing stomach pains and mentioned that she was pregnant, which surprised him as he had no information in this regard previously. He entered the AP's cell and asked her if she was pregnant and if her stomach pain felt like contractions. The AP did not directly respond to those enquiries. Based on his observations, SO5 did not believe the AP required medical attention and asked the guard to continue to monitor the situation and advise him if anything worsened.

Less than an hour later, he received a call from the guard requesting that EMS attend as it appeared that the AP was experiencing a seizure. He attended the AP's cell with two other officers and observed the AP experiencing an active seizure. They placed the AP in the recovery position and EMS arrived approximately five minutes later.

Witness Officers

ASIRT interviewed twelve witness officers. Only three of the officers had any meaningful interaction with the AP. The remaining officers' involvement was mostly limited to intermittent checks on the AP, peripherally moving her in and out of her cell to facilitate hearings or access to the phone while she was in custody, or attending the hospital after the AP's surgery.

WO1 recalled being asked on May 10 to conduct a secondary search on the AP after she had reportedly thrown something out of her cell. While conducting the search in her cell, the AP told her that she was 36 weeks pregnant. She also noted that the AP appeared to be experiencing hallmark symptoms of drug withdrawal. WO1 recalled telling at least the guard on duty, and possibly SO5, that the AP had told her she was pregnant, and she recalled essentially being told that the AP had been "flip-flopping" on this issue.

WO2 recalled making follow-up enquiries of SO1 on May 12 with respect to the AP's medications. He then called VODP and was told that a prescription had been issued. SO1 then advised him that the prescription had been transferred to a different pharmacy. He then went to collect it and obtained instructions on how to administer the medication. Upon his return to the detachment, he conveyed the dosage instructions to the guards and administered the AP her first dose. He had no knowledge that the AP was pregnant.

WO3 attended the AP's cell around midnight on May 13 with SO5 in response to being paged by the guards for an emergency. He observed the AP lying on her back and having a seizure. They opened the cell door and placed her in the recovery position. WO3 continued to try to reassure the AP and ensure that she was breathing as the seizure persisted for what he estimated to be approximately three minutes.

When EMS arrived, WO3 assisted in getting the AP to a seated position. A guard advised EMS that the AP may be pregnant. He noted that based on his own observations of the AP, including having seen the AP's stomach, he would not have thought she was pregnant. When EMS asked the AP directly if she was pregnant, she responded, "I'm not fucking pregnant." WO3 then assisted in getting the AP onto a stretcher and into the ambulance. The AP continued to deny being pregnant when asked again by paramedics. WO3 then attended the hospital with the AP, where he observed the nurse do an ultrasound and confirm the AP's pregnancy. She was then transferred to the maternity ward where she experienced another seizure, which lasted a few minutes. He remained at the hospital until approximately 6:30 a.m., after the AP had been taken into surgery.

Civilian Witnesses

ASIRT investigators interviewed nine additional civilian witnesses, including CW1 and eight cellblock guards. Only five of the guards had any meaningful interaction with the AP.

CW1 confirmed that he had told SO1 the day after his and the AP's arrests that the AP was pregnant and that she needed methadone. He was reassured that SO1 had conveyed this information to the other detachment staff.

Civilian witness #2 (CW2) and civilian witness #3 (CW3) were the guards on duty when the AP was booked into the Lloydminster detachment on May 9. They both recalled hearing the AP tell SO1 that she was at least 36 weeks pregnant. CW2 subsequently searched the AP and had occasion to view her stomach while doing so. She agreed with SO1 that the AP did not look pregnant. CW2 recalled that the AP complained of stomach pain during that first night in custody. She reported this to CW3, who in turn advised SO3, who checked on the AP.

When civilian witness #4 (CW4) attended to relieve CW2 on May 10, she was advised that the AP had told SO1 that she was pregnant but that CW2 did not believe she was. CW4 also noted that it was not listed on the C-13.

When civilian witness #5 (CW5) attended to relieve CW3, she was advised that the AP had initially said she was pregnant but then later told SO3 that she wasn't.

CW4 was standing outside the AP's cell door when she threw a methamphetamine pipe out of the food tray opening. CW4 requested that WO1 complete a secondary search of the AP. Later that day, SO4 facilitated a hearing for the AP and CW4 heard yelling coming from inside the hearing room. She heard SO4 yell, "don't you fucking reach for my…" and she inferred that he was referring to his gun. CW4 yelled for CW5 to push the emergency alarm button and another officer came down to assist SO4 escort the AP back to her cell. CW5 had later clarified with SO4 that the AP had been reaching for his phone and not his gun.

When SO1 re-attended the detachment later that day, he spoke to CW2 and CW5 and advised that CW1 had confirmed that she was pregnant. CW2 still did not believe that to be true.

On May 12, the AP asked CW6 about the status of her medications. He made enquiries of the watch commander and WO2, who took steps to pick up the prescription. CW6 administered the second dose of medication and gave instructions to the next guard on duty about the remaining dose. CW6 expressed concern that at no time was he made aware that the AP may be pregnant.

Later that evening, the AP began complaining of stomach pain and commented, "it's my baby." CW5 observed the AP adopting a position that looked like she may be going into labour. CW5 asked the AP

specific questions to determine if that was the case. The AP denied that she had ever had a baby or that she was in labour. CW5 contacted SO5, who spoke to the AP. SO5 then told CW5 to watch her. CW5 subsequently observed the AP having a seizure and contacted SO5 and EMS. Upon the arrival of EMS, CW5 and one other guard heard the AP tell the paramedics that she was not pregnant.

Cellblock Video

A review of the cellblock video confirmed that most of the AP's time in custody was uneventful and spent lying down in her cell. The guards and officers within the detachment checked on her regularly. The video corroborates the interactions described by the subject officers and other witnesses with the AP.

On May 10, at 2:26 p.m., SO4 opened the AP's cell door. The AP exited her cell, crossed the hallway and entered an adjacent room. This coincides with the time that the AP's bail hearing was facilitated by SO4. There was no available video from inside the hearing room. A few minutes later, the guards can be seen running in the cellblock, and a plain clothes officer arrived at the doorway just as SO4 opened it and exited with the AP. SO4 had his hand on the AP's right shoulder and was directing her back to her cell with minimal force. The AP entered her cell quickly and appeared to slide slightly on the floor before quickly regaining her balance and sitting down on the bench. She appeared agitated bu did not appear to be in any physical discomfort.

Cellblock Policies

The cellblock policies for both Lloydminster and Kitscoty detachments contain similar provisions which expressly assign the responsibility of completing the booking, including completion of the C-13, and addressing any associated concerns including medical treatment or medication needs, to the Kitscoty officers where a Kitscoty prisoner is being detained in the Lloydminster detachment.

The Lloydminster detachment policy stipulates that special attention must be paid to the medical conditions and medications sections of the C-13 during booking. It also prohibits prisoners who are injured, sick, or unconscious from being placed in cells unless they have been examined and deemed fit for incarceration by a physician, and requires ill, injured, or grossly intoxicated persons to be seen by EMS in the cell block or taken to the hospital to be seen by a physician. Guards are required to summon the nearest on-duty officer if a prisoner complains or appears ill or injured.

The policy also stipulates that staggered physical prisoner checks must be conducted at varied intervals, no more than 15 minutes apart. Monitoring of the prisoners may also be augmented using the CCTV. Guards must document any observations made during these prisoner checks, including the prisoner's activity or anything unusual at the time of the check, in the logbook.

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 to the requisite criminal standard.

There was also no evidence that any excessive use of force was applied by any officer to the AP during her arrest or her detention in Lloydminster cells.

There is, however, evidence that demonstrates systemic complacency in the treatment of detainees at the Lloydminster detachment and an inconsistent and ineffective information-sharing process amongst the officers and guards working in the detachment.

The failure to document the AP's possible pregnancy necessarily meant that her reports of stomach pain would be dismissed by anyone unaware of this possibility as exclusively symptoms of withdrawal.

A primary purpose of the C-13, guard logbook, shift notes, and watch commander reports is to ensure continuity of necessary information relating to any detainee's conditions or care as staff changes within the detachment. Anyone dealing with a detainee should be able to rely on the completeness and accuracy of the information provided in those documents. The documents should be updated as new information becomes available. This is a shared responsibility. Information sharing should not rely on a poorly executed game of broken telephone, as was the case in this instance.

It would have been more prudent for SO1 to have listed the possible pregnancy on the original C-13. This was done on the C-13 relating to the AP's detention in January 2024, where the notation read, "may be pregnant." This simple notation would have alerted anyone interacting with the AP thereafter to the possibility of her pregnancy and avoided reliance on mere speculation about the AP and her possible motives to fabricate this information. It would have given requisite context to allow for more meaningful assessment of the AP's subsequent presentation in cells, so that each officer or guard could make an informed decision about whether to request that she receive medical attention.

The officers and guards dealing with the AP early on seemed content to place the onus on the AP to continuously reiterate that she was pregnant, while also in the throes of experiencing withdrawal symptoms. When she did tell someone that she was pregnant, they either did not believe her or did not take any steps to try to confirm the information through alternate reliable means. A non-medical professional deciding that someone does not "look pregnant" is not a substitute for due diligence enquiries. This is particularly the case where a third party had provided confirmation of the pregnancy and a prior prisoner report from a few months earlier, which could have been reviewed, also afforded consistent information.

It is noteworthy that the officers and guards only treated the AP as an unreliable historian where it selectively fit their narrative. They were willing to accept the AP's self-diagnosis that her symptoms were exclusively related to withdrawals and take her denials of the need for any medical attention at face value, yet they disbelieved her when she, and CW1, told them that she was pregnant, which could have equally accounted for some of her symptoms. The overall impression was that the AP, who was an admitted chronic drug user, was somehow deemed less worthy of belief or that she was simply the author of her own misfortune, in terms of the severity of her withdrawal symptoms, due to her drug use. Where a duty of care is owed to detainees that are often vulnerable and marginalized persons, that kind of jaded, indifferent, and unempathetic approach is inappropriate.

The failure to promptly follow up on the AP's request for methadone may have contributed to the AP's seizure. Her medical records attributed the seizure to hypertension, which was a symptom she had been experiencing throughout her pregnancy. SO1 had been put on notice by CW1 that the AP's withdrawals had almost caused a miscarriage previously. However, this information was not conveyed to SO2 or included in any of SO1's shift notes, which may have heightened the sense of urgency in proactively following up on the AP's medications after SO1 initiated the VODP process.

Although VODP confirmed that the responsibility to fill the prescription and notify the RCMP that it was available per the delivery instructions rested with the pharmacy, that does not absolve SO1, SO2, or any officer or guard at the detachment on May 10 or 11 from taking steps to follow up.

After SO1 facilitated a call with the VODP nurse on the evening of May 10, it was understood that a subsequent call with a doctor would be required. The guard logbook recorded that an officer placed her in the phone room again approximately 20 minutes after SO1 facilitated the call with the VODP nurse, which roughly corresponded to the time the AP's prescription was electronically created. Evidently, that officer did not advise anyone that the call with the doctor had been facilitated. This omission left the impression that this step had not yet occurred and that they were either still in a holding pattern, waiting on VODP to complete their assessment, or that the AP had been denied medication. There is also no record of VODP contacting the Lloydminster detachment to advise that the prescription had been sent to a specific pharmacy. The fact that the AP continued to display symptoms of withdrawal and nobody thought to make any follow up enquiries of VODP until WO2 did so on the afternoon of May 12, reflects a troubling sense of apathy.

Each of the officers and guards who acknowledged having been made aware of the possible pregnancy demonstrated indifference towards the AP's well-being and a disregard for ensuring that their colleagues on later shifts were equipped with the most up-to-date information about the prisoners under their care so that they could fulfill their duties effectively. It is not the inaction on the part of any one officer or guard that constituted a departure from the standard of care but the cumulative effect of ineffective communication and information sharing within the detachment across several days where the AP's medication needs went unmet and her symptoms did not improve.

The RCMP detachment policies do not clearly address situations where equivocal information is available relating to a prisoner's medical condition. It is also noted that pregnancy is not an enumerated factor that pre-emptively renders someone unfit for incarceration. Therefore, on a strict reading of the policy, there was nothing mandating that the AP first be examined by a physician before being detained. Although the policy requires "ill persons" to be seen by EMS in the cell block or taken to the hospital to be seen by a physician, the language imports an element of subjective assessment by the booking officer to assess whether a prisoner appears sufficiently ill.

In this case, the officers' own observations of the AP were reportedly inconsistent with indicia they would have expected to see if the AP was 36 weeks pregnant as she stated. SO1 had reason to believe that the AP may have been lying about her pregnancy, just as she had lied about her name and date of birth when he had interacted with her earlier that day, in the hopes of avoiding arrest or detention. CW1's confirmation of the AP's pregnancy on May 10 did not alter SO1's assessment of the veracity of the claim, but it did prompt him to connect the AP to the VODP program.

Throughout her detention, the AP appeared to be mostly fine, as she slept for much of the time. There were obvious signs that the AP was experiencing withdrawals, which the AP herself attributed her symptoms to. However, none of the guards or officers perceived her to be in any medical distress until

she began seizing. The guards conducted regular physical checks and when the AP made any complaints, such as having a sore stomach, they promptly notified the watch commander who attended the AP's cell and spoke with her. When offered the opportunity to be seen by EMS or taken to hospital, the AP declined.

As soon as the AP's medical distress was noted, the guards and officers on duty acted quickly and properly. They called EMS while providing the medical care that they were able to.

There is no evidence to suggest that earlier treatment would have prevented the death of the AP's child. Multiple causes were cited as contributors to the child's natural death, including factors, such as the AP's chronic drug use, that pre-existed her detention and were outside of the control of any of the guards, officers, or medical professionals.

Conclusion

ASIRT was directed to investigate the circumstances of the AP's detention in the custody of the RCMP, which may have contributed to the death of her baby. While the baby's death was untimely and tragic, there are no reasonable grounds to believe that any officers committed an offence.

Original Signed

Matthew Block

Acting Executive Director

March 19, 2026

Date of Release