

ASIRT DECISION

**IN THE MATTER OF A DEATH IN ST. PAUL RCMP
CELLS ON MARCH 19, 2025**

Acting Executive Director: Matthew Block

File No.: 2025-0010(N)

Date of Release: June 24, 2026

Introduction

On March 19, 2025, 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 St. Paul Royal Canadian Mounted Police (RCMP). 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 one subject officer and provided him with notice. They also investigated the actions of a civilian guard and made her aware of her potential criminal jeopardy. 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 eight police officers. Only two of the officers had any interaction with the AP at the detachment when he was lodged. The remaining officers either had prior interactions with the AP, or their involvement was limited to attending cells after the AP was believed to be experiencing medical distress.

ASIRT investigators also interviewed four civilian witnesses, including the following:

Civilian Witness #1 (CW1) – a civilian cell guard on duty at the St. Paul RCMP detachment between 4 p.m. and midnight on March 18, 2025;

Civilian Witness #2 (CW2) – a civilian cell guard on duty at the St. Paul RCMP detachment between 12 a.m. and 8 a.m. on March 19, 2025;

Civilian Witness #3 (CW3) – a civilian cell guard trainee who was present at the St. Paul RCMP detachment on March 19, 2025; and

Civilian Witness #4 (CW4) – a registered psychiatric nurse who worked with the regional police and crisis team (RPACT) who interacted with the AP on March 18, 2025, and attended the St. Paul RCMP detachment on March 19, 2025.

As the subjects of a criminal investigation, the subject officer and civilian guard are entitled to rely on their right to silence and not speak to ASIRT. In this case, subject officer #1 (SO1), an RCMP officer, provided ASIRT investigators with a written statement and answered questions in an interview. The civilian cell guard provided a written statement. For ease of reference, the guard will be referred to as subject officer #2 (SO2) throughout this report, despite not being a police officer or peace officer.

ASIRT investigators reviewed all available video of the incident, including footage from inside the St. Paul RCMP detachment and the cellblock, body worn camera (BWC) footage of three officers, and WatchGuard video footage from inside SO1's police vehicle used to transport the AP to the police detachment. They also oversaw a scene examination conducted by RCMP Forensic Identification Service members.

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

ASIRT investigators also reviewed the prisoner logbook completed by the guards, and other documentation created by officers relating to the AP's detention.

ASIRT investigators also reviewed the RCMP and St. Paul detachment policies relating to prisoner care.

Circumstances Surrounding the Incident

On March 18, 2025, at 9:13 p.m., St. Paul RCMP officers were dispatched in response to a complaint that the AP, identified by name, was lying across the front steps of a residence, blocking access to the door. The complainant reported that the AP appeared to be intoxicated and observed that he had only one leg. A wheelchair was also noted to be positioned in front of the residence.

SO1 attended the location and found the AP lying on a landing at the top of two steps leading to the residence's front entrance. The AP's wheelchair was located on the sidewalk at the base of a cleared pathway leading to the residence. The AP was arrested for mischief, though he was not handcuffed. He was assisted into his wheelchair and subsequently helped into the police vehicle.

The AP was transported to the St. Paul RCMP detachment, arriving at 9:33 p.m. During transport, the AP denied consuming alcohol or drugs. He stated that he had broken ribs, cancer, and was sick. He further advised that he had been kicked out of the hospital earlier that day for allegedly being abusive, which he denied. The AP requested to be taken home; however, SO1 informed him that he would instead be taken to the detachment so that he could remain warm, rest, obtain food, and be released the following day.

Video footage from the detachment shows the AP being assisted from the police vehicle and searched. He was cooperative and complied with all directions provided. He requested assistance removing his shoe and outer clothing, which officers provided, before being placed in cell nine. The AP independently transferred himself from his wheelchair onto the cell bench, where he lay on his side. He remained in the cell thereafter under the supervision of civilian guards, including CW1, CW2, SO2, and CW3.

Throughout his detention, the AP was intermittently active, alternating between lying down and sitting upright. He removed his shirt at one point and moved along the bench between his mattress and the toilet on several occasions. At approximately 10:35 p.m., he was observed inserting his fingers into his mouth and vomiting liquid onto the floor before lying down again. The vomit subsequently dried and was no longer visible. On several occasions, the AP knocked on the cell door; guards responded and provided him with a cup, which he used to obtain water from the in-cell fountain. He later moved the mattress to the floor and lay on it.

At approximately 2:19 a.m., the AP again appeared to retch, spit, insert his fingers into his mouth, and dry heave intermittently over a 15-minute period. At 2:42 a.m., a guard responded to his knocking and provided him with a cup of sugar water, which he consumed. He then continued alternating between lying down and sitting up. Between 5:30 a.m. and just before 8 a.m., the AP intermittently knocked on the cell door and called out, then returned to lying down.

At 7:56 a.m., the AP moved himself to the bench near the cell door, put his shirt back on, and positioned his wheelchair in front of him. He was observed occasionally touching his chest and appeared to be experiencing some respiratory difficulty, alternating between deep and shallow breathing as evidenced by the movement of his chest. At 8:03 a.m., he appeared unable to remain

upright, pitching forward twice into his wheelchair before leaning back against the wall. He then slumped to his right side, briefly sat upright again, and repeated this pattern several times. At 8:09 a.m., he vomited a reddish-brown substance onto the bench and again approximately six minutes later. The vomit flowed from the bench onto the mattress below.

After this point, the AP lay on his right side with his head resting on the bench. His left arm was bent at a 90-degree angle at the elbow, with his left wrist flexed and the top of his hand resting near his waist. He did not move from this position thereafter.

SO2 began her shift at 8 a.m. and conducted physical checks of the AP at 8:55 a.m., 9:35 a.m., 9:54 a.m., 10:11 a.m., and 10:25 a.m.

Shortly before 10:30 a.m., RCMP officers entered the AP's cell and attempted, unsuccessfully, to rouse him. He was then moved to the floor, and chest compressions were initiated. EMS arrived at 10:37 a.m. and continued resuscitation efforts until the AP was pronounced deceased.

An autopsy conducted by the Office of the Chief Medical Examiner (OCME) on March 24, 2025, determined that the cause of death was complications of perforated duodenal ulcer. The manner of death was classified as natural. No other significant injuries were identified, aside from rib fractures associated with resuscitation efforts.

The medical examiner further confirmed that the AP had presented twice to the St. Paul Healthcare Centre earlier on March 18, 2025. At approximately 5 a.m., he sought assistance due to homelessness, exposure to cold, and requested shelter, as well as an assessment of his right amputation site. He was treated with antibiotics and discharged. At approximately 2 p.m., he returned via EMS after reportedly falling from his wheelchair, complaining of shoulder, arm, and abdominal pain. No rib fractures were identified, and no diagnostic imaging was performed. He received fluids and was noted to be verbally abusive towards staff. The records do not clearly indicate whether he was formally discharged or left against medical advice.

Police Witnesses

Eight police witnesses were interviewed by ASIRT; however, only two had direct involvement with the AP during his detention. The following summarizes those officers' interactions with the AP and the information they provided.

Witness officer #1 (WO1) and witness officer #2 (WO2) were both present at the St. Paul RCMP detachment when SO1 arrived with the AP. Each officer had prior dealings with the AP on numerous occasions.

WO1 completed the prisoner report (Form C-13) while SO1 conducted a search of the AP with assistance from WO2, who stabilized the AP's wheelchair – missing one wheel – to prevent him from falling. WO1 observed that the AP was grunting, groaning, and appeared to be in discomfort, which WO1 indicated was not unusual given the AP's leg amputation. The AP did not identify any specific source of pain. Aside from difficulties related to his wheelchair, WO1 did not observe anything out of the ordinary. He assessed the AP as exhibiting his typical level of intoxication and noted no indicators that medical attention was required. The C-13 was completed consistent with these observations.

WO2 advised that SO1 lodged the AP in cells due to unsafe outdoor conditions, particularly the cold, and noted the absence of a men's shelter in St. Paul, as well as the AP's lack of family support. WO2 stated that local RCMP members routinely attempted to look out for the AP's wellbeing under such

circumstances. He described the AP as calm and cooperative on this occasion. The AP did not raise any complaints or express that anything was wrong, and WO2 noted that the AP would typically articulate concerns, particularly regarding his leg, when issues arose. On this occasion, the AP's only request was that his wheelchair remain with him in the cell, which WO2 permitted.

Civilian Witnesses

ASIRT investigators interviewed four civilian witnesses.

CW1 advised that she was present when the AP was admitted to cells on March 18, 2025, and that she monitored him until midnight. The AP was permitted to keep his wheelchair with him in the cell. During her watch, CW1 observed the AP placing his fingers down his throat and drinking from the toilet. She described his demeanour on this occasion as calmer than during a prior interaction when she had also been responsible for guarding him.

CW1 explained that her duties included conducting regular prisoner checks from the cell door and documenting detainee activity approximately every eight to ten minutes. She indicated that, where a prisoner was actively moving, checks could be conducted via CCTV. She further noted that entries in the logbook did not distinguish between checks conducted in person and those conducted via CCTV.

CW2 advised that he had previous dealings with the AP in cells and described his demeanour as variable. On this occasion, however, the AP was polite and cooperative. CW2 reported that the AP slept for most of the night but vomited on a few occasions, which CW2 characterized as typical behaviour for the AP. The AP made several routine requests, which CW2 accommodated, including providing him with a cup to drink water from the cell fountain and later a cup of sugar water. CW2 stated that the AP did not request medical attention. He added that, on a prior occasion when the AP had requested to attend hospital, he had taken steps to notify an RCMP member to facilitate a medical assessment.

CW3 reported that he arrived at the St. Paul RCMP detachment at 8:24 a.m., while another detainee was being processed. He was undergoing training with SO2 at the time. CW3 initially estimated that his first physical check of the AP, conducted with SO2, occurred approximately 30 minutes after his arrival, around 9:05 a.m., but later revised this estimate to approximately 8:37 a.m. During this check, he observed the AP lying on a bench, with what appeared to be vomit present. Cellblock video footage confirms that the first physical check conducted by SO2 and CW3 occurred at 8:55 a.m.

At 9:54 a.m., CW3 accompanied SO2 for another physical check. During this interaction, SO2 instructed CW3 on how to assess a detainee's breathing, directing his attention to movement along the AP's side. CW3 observed the AP's shirt moving and concluded that he was breathing.

At 10:10 a.m., CW3 observed that the AP appeared to be in an unusually uncomfortable position and remarked that it did not seem plausible that a person could remain in such a posture for an extended period. In response, SO2 attended at the cell door, kicked it, and called out the AP's name. CW3 observed this via CCTV. SO2 subsequently returned to the guard desk and advised that the AP appeared to be in a deep sleep. At 10:25 a.m., SO2 returned to the cell, knocked on the door again, and then directed that an RCMP member be called to check on the AP.

It is noted that the times provided by CW3 generally align with entries in the prisoner logbook, though minor discrepancies of a few minutes were observed when compared with the cellblock video footage.

CW3 further advised that during his training, SO2 instructed him that if required checks were missed and the detainee remained in the same position as during the last observation, the missed checks

could be entered retrospectively using the same information. CW3 indicated that two such checks were missed following his initial observation of the AP. These were recorded in the logbook at 9:13 a.m. and 9:27 a.m. Review of the cellblock video footage confirms that no physical checks were conducted at those times. In fact, no physical checks were observed between the check conducted at 8:55 a.m. by SO2 and CW3 and the subsequent check conducted by SO2 at 9:35 a.m.

CW4 provided contextual information regarding the AP's prior interactions with RPACT. She advised that she had attended at the hospital on March 18, 2025, where the AP signed documentation to assist in securing a replacement wheelchair. She was also working to connect him with Assertive Outreach Services, noting that he was vulnerable, unhoused, had limited community supports, and experienced ongoing physical health complications related to his amputation, as well as issues with substance use.

CW4 learned the following day that the AP had left or been discharged from the hospital and had been arrested and detained overnight at the RCMP detachment. She noted that RCMP members frequently lodged the AP in cells for his own safety, particularly to protect him from exposure to the elements, and that he was consistently treated with respect.

On March 19, 2025, CW4 attended at the detachment to visit the AP, but was advised by SO2 that he was sleeping. She observed via CCTV that the AP appeared to be asleep on the cell bench and departed without speaking to him. She later learned that the AP had died while in custody. CW4 expressed concern that the hospital had permitted him to leave the previous day but was unable to comment on whether he had been formally discharged or had left against medical advice.

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 SO1 submitted to an interview. However, each of the subject officers provided a prepared written statement.

Subject Officer #1 (SO1)

SO1 reported that on March 18, 2025, at 9:17 p.m., he was dispatched to a complaint involving a male with a wheelchair lying on the front steps of a residence. The male was described as awake, missing one leg, and was speaking with the complainant's son. The duration of his presence at the location was unknown, and he was believed to be intoxicated. The complainant's son had attempted to repair the male's wheelchair; however, the male remained on the steps. Based on this information, SO1 believed the individual to be the AP, with whom he had prior dealings on approximately 10 to 12 occasions.

Upon arrival, SO1 observed the AP lying down on the steps outside a duplex residence. The AP's wheelchair, which was missing a wheel, was located approximately eight to ten metres away on the sidewalk. SO1 formed the impression that the AP had crawled through the snow to reach the steps. He retrieved the wheelchair and approached the AP and engaged him in conversation. The AP stated that he was sick, had been removed from the hospital, and wished to return home. SO1 believed the AP to be under the influence of alcohol and interpreted his comment about being "sick" as relating to the cold weather conditions. Given the low temperature, SO1 determined that the AP required shelter in a warm environment.

SO1 decided to transport the AP to the detachment so that he could remain there overnight, warm up, and sober up. He recalled a prior, similar interaction in which the AP's mother declined to allow the AP

to be brought to her residence due to concerns related to his substance use and associated behaviour. SO1 concluded that, as on previous occasions, the AP was intoxicated and lacked a suitable or available place to go. He did not transport the AP to hospital, as he understood that the AP had already been expelled from that facility earlier in the day.

SO1 arrested the AP for mischief, noting that an arrest for public intoxication would also have been available. He advised the AP of his *Charter* rights; however, the AP's responses were largely mumbled and incoherent. SO1 then transported the AP to the St. Paul RCMP detachment. During transit, SO1 attempted to clarify the circumstances surrounding the AP's removal from hospital and understood the AP to allege that hospital staff were racist and did not want him there.

Upon arrival at the detachment, WO1 assisted by completing the prisoner log report, while SO1 conducted a search of the AP. The AP was then lodged in cell nine.

Subject Officer #2 (SO2)

SO2 reported that she commenced her shift at the detachment at approximately 7:45 a.m. on March 19, 2025. Upon arrival, she was briefed by CW2, who advised that the AP had been restless throughout the night, complained of abdominal pain, vomited on several occasions, and had ultimately settled and fallen asleep. SO2 further indicated that she was responsible for training a new civilian guard, CW3, that morning and conducted two prisoner checks prior to his arrival.

SO2 advised that she conducted checks on the AP at 8:10 a.m., 8:25 a.m., 8:37 a.m., 8:50 a.m., 9:00 a.m., 9:13 a.m., 9:27 a.m., 9:40 a.m., 9:54 a.m., 10:10 a.m., and 10:25 a.m., documenting each in the prisoner logbook. She noted that the AP's positioning varied over time, including lying on his left side, right side, and back. She recorded that, as of 9:13 a.m., the AP remained lying on his left side. During the 9:40 a.m. check, SO2 instructed CW3 on how to assess whether a detainee was breathing, indicating that the AP's breathing could be observed through the movement of his chest. She advised that CW3 confirmed he could see the AP breathing.

SO2 stated that at approximately 10:25 a.m., she became concerned when she was unable to observe any chest movement, and the AP did not respond to her attempts to rouse him by knocking on and shaking the cell door and calling out his name. She then directed that an RCMP member attend. Upon entering the cell, responding officers observed that the AP was unresponsive and immediately initiated chest compressions. EMS attended shortly thereafter, at approximately 10:40 a.m., and assumed resuscitation efforts.

SO2 further advised that she had known the AP for approximately three years through her work at the detachment. She stated that RCMP members and civilian guards consistently treated the AP with kindness and respect and made efforts to ensure his safety and wellbeing in light of his physical health issues, mental health challenges, and substance use concerns.

RCMP Policies

There is a St. Paul Detachment policy and a national RCMP policy on the care and handling of prisoners. They set out guidelines for completing both physical and visual checks on prisoners and maintaining appropriate documentation of those checks in a Prisoner Log Record Book. Physical checks involve a guard attending individual cells and looking through a window to observe the prisoner; whereas, visual checks may be conducted via CCTV and augment, but do not replace, physical checks.

These policies stipulate that cellblock guards are required to conduct physical prisoner checks at irregular intervals, not more than 15 minutes apart. Guards must then 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. The national policy further specifies that guards must ensure that intoxicated persons are awake or awoken and responsive a minimum of once every four hours.

The St. Paul detachment cellblock policy further 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 cellblock or taken to the hospital to be seen by a physician. Intoxicated prisoners are required to be placed in one of two designated cells, including cell nine. Guards are required to summon the nearest on-duty officer if a prisoner complains or appears ill or injured.

The prisoner logbook confirms that only two prisoners were in custody at the detachment between 10:08 p.m. on March 18, 2025 until 8:27 a.m. the following morning, when a third prisoner was admitted.

The prisoner log entries completed by SO2 in relation to the AP indicate that physical checks were conducted at irregular intervals, not exceeding 15 minutes, beginning at 8:10 a.m. However, a review of the cellblock video footage establishes that, after commencing her shift at 8 a.m., SO2 conducted physical checks of the AP at approximately 8:55 a.m., 9:35 a.m., 9:54 a.m., 10:11 a.m., and 10:25 a.m. Accordingly, only three physical checks were conducted during the first two hours of her shift. It is noted that SO2 was responsible for processing the admission of a third prisoner at 8:27 a.m. and, at or about the same time, began training a new civilian guard, CW3. These concurrent responsibilities would have affected her ability to conduct more frequent in-person checks during that period.

With respect to other checks recorded in the logbook – specifically those at 8:19 a.m., 8:32 a.m., 8:44 a.m., and 9:06 a.m. – video footage shows SO2 seated at the guard desk, where CCTV monitors displaying the cells were located. While the camera angle does not permit confirmation of whether SO2 was actively observing the monitors, she appears to have been making entries in the log book at or near those times. This suggests that these entries may have been based on observations made via CCTV. It remains unclear whether it was standard practice to distinguish between physical and CCTV checks in the log book, despite the presence of separate columns for each. With the exception of an additional entry at 9:27 a.m., the log entries appear to correspond generally with checks conducted either by CCTV or by observation through the cell door window.

Notwithstanding the above, the reliability of certain log entries is open to question. SO2's entries frequently indicate that the AP was observed sleeping on his left side and, at times, suggest that he changed position during the morning. However, the video evidence does not show the AP moving after approximately 8:09 a.m., when he slumped onto his right side and vomited – an event that occurred prior to SO2's first recorded entry 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 necessities of life and criminal negligence causing bodily harm or 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 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 of his lawful arrest, the AP exhibited some signs of intoxication. No use of force was observed during the arrest. Throughout his interaction with the AP, SO1 demonstrated a notable degree of empathy and professionalism. His actions reflected a concern for the AP's safety, particularly in light of the cold weather conditions, and he determined that lodging the AP at the detachment overnight was the only viable means of protecting him from the elements.

Upon arrival at the detachment, the AP retained sufficient mobility to transfer himself into and out of his wheelchair without significant assistance. He was responsive, cooperative, and compliant with police directions. No injuries were observed. Although the AP was noted to be grunting and groaning, SO1 reasonably attributed this to discomfort arising from prolonged exposure to the cold and his circumstances outside without access to his wheelchair. SO1 was also aware that the AP had reportedly been discharged from hospital earlier that day. There was nothing in the AP's presentation to suggest the presence of a serious underlying medical condition or a level of intoxication that would render him unfit for detention or necessitate a medical assessment prior to being lodged. SO1, WO1, and WO2 each described the AP's presentation as consistent with his typical behaviour. WO2 further noted that the AP would ordinarily communicate any need for medical attention but did not do so on this occasion.

Over the course of the following approximately 12 hours, there were no clear indicators that the AP was experiencing medical distress. Neither the civilian guards monitoring him nor the available CCTV footage revealed any obvious cause for concern until approximately 8:09 a.m., when the AP slumped onto his side and vomited. He thereafter remained in the same position for an extended period. CW2 indicated that the AP frequently vomited while in cells due to intoxication and that this behaviour alone was not unusual or cause for concern. It is also noted that the CCTV footage lacked audio and was of insufficient quality to allow for observation of subtle indicators such as chest movement consistent with breathing.

CW1 and CW2 conducted regular checks of the AP throughout the night. After SO2 commenced her shift at 8 a.m., she undertook a series of physical and CCTV checks, although these did not strictly comply with the requirement that physical checks be completed at irregular intervals not exceeding 15 minutes. It appears that SO2 relied more heavily on CCTV monitoring during this period, which may be partially explained by her simultaneous responsibilities, including the intake of a third prisoner and the training of CW3.

It is also noted that some of the most pronounced indicators of potential medical distress – specifically, signs of respiratory difficulty and an apparent inability to maintain an upright seated position prior to the AP slumping onto his right side – appear to have occurred within a brief interval, estimated at less than 15 minutes, during which responsibility for monitoring the cell block was

transitioning from CW2 to SO2. Any conclusion as to whether these observations might have prompted an earlier request for medical assessment would be speculative.

At 9:54 a.m., both SO2 and CW3 formed the view that the AP was breathing. Subsequently, CW3 expressed concern that the AP appeared to be in an unusually uncomfortable position and had not moved. SO2 conducted two further checks within the following 30 minutes. After the first, she indicated her belief that the AP was in a deep sleep. However, when the AP remained unresponsive during the second check, she directed that RCMP members attend. The available evidence does not establish the precise time at which the AP ceased breathing. SO2 and CW3, who observed him directly at the cell, as well as CW4, who viewed him via CCTV, all believed that he was asleep. While this assessment was ultimately incorrect, it was one they were reasonably entitled to make based on the information available to them at the time.

Once the AP's medical distress was recognized, SO2 responded promptly and appropriately. She immediately notified the RCMP members, who attended at the cell, initiated resuscitative efforts, and requested EMS. Officers provided the medical care that they were able to until EMS arrived. On the evidence, there are no grounds to conclude that there was negligence or a failure to provide the necessities of life.

Conclusion

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

Original Signed

Matthew Block
Acting Executive Director

June 24, 2026

Date of Release