Feb. 25, 2019

Woman’s in-custody death result of medical event

On Aug. 7, 2017, the Alberta Serious Incident Response Team (ASIRT) was directed to investigate the circumstances surrounding the death of a 55-year-old woman following her arrest and detention by members of the Edmonton Police Service (EPS).

ASIRT’s investigation was comprehensive and thorough, conducted using current investigative protocols and in accordance with current best practices. Evidence gathered included interviews with relevant police and civilian witnesses, including the woman’s two daughters, who had been with her at the time of her arrest. Additionally, the entirety of the woman’s contact with police, both at the Belvedere LRT station and at EPS Northeast Division and the Detainee Management Unit (DMU), with very limited exceptions, was captured on available CCTV recordings. All EPS officers and community peace officers who had contact with the woman cooperated fully and provided statements.

The events relevant to the investigation commenced on Aug. 6, 2017, when two EPS officers attended the Belvedere LRT station on a 911 call of a possible attempted suicide. At approximately 2:36 p.m., a young woman, intoxicated by alcohol, jumped onto the LRT tracks and lay down on them. Her sister jumped down and helped the young woman back onto the platform. Upon their arrival, the officers located the two younger women and their 55-year-old mother. All three women appeared to be intoxicated, to varying degrees. The woman who had lain on the LRT tracks was arrested for public intoxication. The second woman was determined to have an outstanding warrant and was also arrested. While this was occurring, their 55-year-old mother wandered off.

As police were dealing with the two women, they were advised that a 911 call had been made by their mother, sounding intoxicated, who reported that her daughters had been bear-sprayed and put into the back of a police car at the Belvedere LRT station. Officers knew they had not bear-sprayed the women and therefore believed the complaint to be false. One of the officers found the 55-year-old woman sitting outside near an entrance to the LRT station, yelling and swearing at patrons as they exited the LRT station, and calling them pigs or saying they smelled like pigs. It was determined that she had placed the 911 call and was arrested at approximately 3:10 p.m. for causing a disturbance and making a frivolous 911 call under the Emergency 911 Act. He escorted her back to the patrol vehicle. A police information check confirmed additional outstanding warrants for theft and two counts of failure to appear, and that she was also out on bail for other offences. The 55-year-old woman and the daughter who had been arrested for public intoxication were transported to Northeast Division. The third woman was released from the scene on a Promise to Appear.

At Northeast Division, the 55-year-old woman was searched by a female officer and placed into a holding cell by herself at 3:37 p.m. On the CCTV recording, she was able to walk unassisted while handcuffed. She was also able to balance on one leg while removing footwear. Her time in custody was uneventful. On her intake assessment log, notes were made that the woman mentioned oxygen and identified pre-existing medical conditions.
At 7:31 p.m., the woman and other detainees were transported to the EPS Detainee Management Unit (DMU) to be lodged until they could be brought before a justice of the peace for a bail hearing.

The woman was booked into DMU at 8:07 p.m., intake screening was completed and she was searched. During the screening intake, the woman admitted to drinking vodka coolers, identified pre-existing medical conditions, and indicated, when asked, that she did not require medication in the next 24 hours, nor did her medical conditions require any medical attention in the next 24 hours. She denied having any non-prescription drugs in the preceding 24 hours.

Upon being lodged into DMU, the woman was placed into a cell where another female detainee was being held. A fixed camera above the entrance door allowed for live-monitoring of the detainees and recorded continuously. The woman and her cellmate had no altercations in the cell for the duration of their detention. The original detainee left shortly after midnight and was replaced by another detainee. A short time later, a third female entered the cell during the night of Aug. 6. All three women co-existed in the cell without incident. The woman was removed from the cell between 9:17 p.m. and 9:37 p.m. to be fingerprinted/photographed and to use the telephone.

On Aug. 7, 2017 at 7:05 a.m., a Community Peace Officer (CPO) distributed a breakfast meal to the detainees, including the woman. The CPO asked her if she wanted a sandwich and she replied “No.” He asked if she wanted one for later and she again replied “No.” On video, she can be seen looking up at the CPO and appearing to be interacting/responding to the CPO. She was in a seated position. Nothing about the interaction suggested to the CPO that she was in medical distress, nor are signs of medical distress observed on video.

At 8:09 a.m. on Aug. 7, the woman was in a seated position on the floor, when she tipped over onto the floor onto her right side. Her left arm reached out to cushion the blow. Her head struck the floor but did not appear severe enough to have caused any injury. She remained lying on the floor but continued to move frequently. It was not clear from the video if she was conscious or unconscious but frequent movements indicated that she was likely breathing and exhibiting signs of life.

At approximately 10:02 a.m., another CPO was conducting the mandatory physical cell checks when she heard laboured breathing in the woman’s cell and felt she could be in medical distress. With the assistance of another CPO, they entered and were unable to rouse the woman, who was still breathing but was unresponsive to physical touch or auditory stimulus. Emergency Medical Services (EMS) were called, quickly assessed the woman and then transported her to hospital. Hospital staff advised police that the woman had suffered a “brain bleed” (internal hemorrhage) and that her condition was life-threatening. Police were asked to locate and advise next-of-kin. The woman passed away in hospital later that evening.

In relation to the CCTV system, DMU staff do not have access or the capacity to playback, review or erase video footage recorded by the system. Essentially, the only access is via a live feed. Cell checks are electronically recorded and also physically logged by the CPOs. As well, all movements by staff and detainees within DMU are captured on the CCTV system. The evidence established that regular, required cell checks were conducted in this case.

A careful and repeated review of the video identified that at approximately 2:20 a.m. on Aug. 7, 2017, the woman appeared unsteady on her feet and possibly somewhat disoriented. During the next hour, she appeared to have increasingly diminished movements of her right side extremities and she slipped off the bench onto the floor. The decline in her movements occurred over the span of approximately one hour. Occasionally, her right arm would move but not regularly. The changes were extremely subtle.
For the next 4-5 hours, the woman remained seated on the cell floor, conscious, sitting upright and moving only her left side extremities. During that time, the other two women in the cell appeared primarily sleeping, one on the floor.

An autopsy was conducted on Aug. 9, 2017. In a report from the Office of the Chief Medical Examiner (OCME), an acute hemorrhagic stroke was identified as the primary cause of death with other significant contributory pre-existing medical conditions and methamphetamine use prior to death. OCME concluded that the cause of death was a medical episode, not trauma-related. It was confirmed at autopsy that certain underlying disease would have contributed to blood's inability to clot, which would aggravate the impact of the stroke. Toxicology testing detected low levels of methamphetamine and diazepam. The autopsy report indicated that the use of stimulant drugs could have been associated with a rise in blood pressure, which could increase the risk of the type of stroke that occurred in this case.

One concern identified by the woman’s family was that she had respiratory issues and used an oxygen tank, although she did not have a tank with her at the time of her arrest. At autopsy, chronic lung disease was confirmed by microscopic examination but was not felt to be causative or contributory to death in this case.

Another concern identified by the family were bruises observed on the woman in hospital. At autopsy, the external examination showed the presence of scattered, mostly small, bruises predominantly involving the extremities. There was no indication of internal trauma associated with the bruises. Furthermore, the bruises were in various different stages of healing. It should be noted that attempts to “date” bruising are notoriously unreliable, thus it would be impossible to make any reliable determinations as to when the bruises were sustained. As such, it was confirmed that any existing bruising did not cause or contribute to death. Regardless, a careful review of the CCTV recordings confirmed no use of force by police, with the exception of incidental contact in the placement or removal of handcuffs or holding the woman by the arm (for example: while placing or removing the woman from the police car.)

When police officers take custody of a person, they owe a significant duty of care to ensure the safety of that person. It is a particularly important responsibility. Those in custody can often be amongst the most vulnerable, including those intoxicated by alcohol or drugs, and those with underlying physical or mental health issues. The woman in this case was one such person. She was intoxicated at the time of her arrest and detention, she was of a somewhat advanced age and had underlying health issues.

It must be remembered, however, that what is required is a reasonable standard of care, not perfection. As such, what is required is reasonable supervision and care based on the available circumstances as they present.

In these types of cases, the potential liability stems not from the actual commission of an act but rather whether there has been an omission or failure to act. It is a culpability based on a form of negligence. Any potential liability would relate to the failure to ensure adequate supervision to ensure that any ensuing medical crisis was identifiable in a timely fashion and that medical care was provided as needed.

In this particular case, the ability to carefully and repeatedly review the hours of detention -- knowing as the review is occurring that something happened to the woman that would send her into medical distress -- allowed an observer to identify the most likely point where it appears that the woman’s stroke may have occurred. The changes were, however, subtle and could have been
masked to the ordinary observer, exercising reasonable supervision, as consistent with intoxication and/or sleep. Unfortunately, it is unlikely that anyone understood what was happening, including the woman. That is one of the more insidious and dangerous aspects to a stroke. Without immediate recognition that a stroke is occurring, the damage that occurs is often catastrophic, if not fatal. Even after the point when it appears that the stroke occurred, the woman continued to be responsive to questions and cell checks, did not raise any health concerns or seek assistance. The observations of the woman were consistent with what one might encounter in an intoxicated person in custody. While the stroke was more easily recognized after the fact, with the benefit of continual visual observation, the signs were not so easily discerned in the circumstances as they occurred.

The Edmonton Police Service has strict prisoner management processes and it is very clear that all the necessary prisoner checks were made. All systems were functioning properly during the woman’s detention and all evidence confirmed that staff fulfilled the mandated supervision. While there are things that could have been altered in the case, for example, to ensure that an assessment of the woman’s need for oxygen was addressed, there is no evidence to suggest that it would have resulted in a different outcome, no matter how tragic that outcome was. The woman’s death was the result of a medical event that could have occurred anywhere, at any time, and there is no evidence to suggest that the care and supervision provided, which would meet the required reasonable standard of care, played any role in her death.

Notwithstanding these findings, this was an unexpected and devastating shock to this woman’s family and friends. ASIRT’s sincere condolences go out to them as they continue to grieve.

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