SiRT | SERIOUS INCIDENT RESPONSE TEAM

Summary of Investigation

SiRT File # 2025-0014

Referral from

RCMP “H” Division

February 11, 2025

Erin E. Nauss
Director
May 2, 2025

MANDATE OF THE SiRT

The Serious Incident Response Team ("SiRT") has a mandate to investigate all matters that involve death, serious injury, sexual assault, and intimate partner violence or other matters determined to be of a public interest to be investigated that may have arisen from the actions of any police officer in Nova Scotia and New Brunswick.

At the conclusion of every investigation, the SiRT Director must determine if criminal charges should result from the actions of the police officer. If no charges are warranted the Director will issue a public summary of the investigation which outlines the reasons for that decision, which must include the information set out by regulation. Public summaries are drafted with the goal of adequate information to allow the public to understand the Director's rationale and conclusions.

Mandate invoked: This investigation was authorized under Section 26I of *Police Act* due to the death of the Affected Party.

Timeline: SiRT commenced its investigation on February 11, 2025. The investigation concluded on April 1, 2025.

Terminology: This summary uses the following language in accordance with regulations made under the *Police Act* and to protect the privacy of those involved:

- "**Affected Party/AP**" means the person who died or was seriously injured in relation to a serious incident.

- "**Civilian Witness/CW**" means any non-police individual who is a witness to or has material information relating to a serious incident.

- "**Witness Officer/WO**" means any police officer who is a witness to or has material information relating to a serious incident.

- "**Subject Officer/SO**" means a police officer who is the subject of an investigation, or whose actions may have resulted in a serious incident.

Evidence: The decision summarized in this report is based on evidence collected and analyzed during the investigation, including, but not limited to, the following:

1. Initial Occurrence Police Report and Police Phone Call
2. Police Radio Transmissions
3. Witness Officer Reports and Statements (10)
4. Civilian Statements (8)
5. Autopsy Report of the Affected Party
6. Body Worn Camera Footage
7. Cell Block Video from Digby RCMP Cells
8. Video from local businesses
9. Forensic Identification Services (FIS) Reports (including scene photos and video)
10. Policy Manuals
11. Prisoner Logbook

INVESTIGATION SUMMARY

Introduction

On February 10, 2025, at 3:18 pm RCMP officers responded to a call of an intoxicated person behind the mall in Digby, Nova Scotia. Upon arrival, officers located the Affected Party (the "AP") laying in the snow. The AP was arrested for being intoxicated in a public place, was transported to the RCMP detachment and placed in cells. Officers decided to keep the AP in cells until he became sober or a family member was able to take him.

Police were unable to locate anyone to take the AP and he remained in cells overnight. During his stay in cells, the AP was displaying signs of intoxication, including being unsteady on his feet and vomiting. The AP was observed moving and breathing throughout the night. The following morning, the AP was using the toilet and hit his head on the wall. Shortly after, he became unresponsive and appeared to be in medical distress. Emergency Health Services ("EHS") was contacted and attended the detachment. They provided immediate care to the AP and transported him to hospital for further medical intervention. The AP was pronounced deceased at the hospital later that morning. SiRT was contacted following the AP's death. An autopsy determined the AP died of natural causes, being an upper gastrointestinal hemorrhage caused by chronic ethanol use.

Note: due to the nature of the incident, information gathered, and the roles of the officers, there was no Subject Officer identified in the course of the investigation.

Initial Call/Response

Civilian Witness #1 ("CW1") contacted the RCMP on February 10, 2025, at 3:18 pm, advising the AP was passed out in the snow. Three officers (Witness Officers 1-3/WOs 1-3) responded and located the AP. On February 11, 2025, CW1 provided a statement to SiRT. He stated he was driving when he noticed the AP was curled up in a snowbank, trying to stay warm. He was wearing boots and a winter jacket, but did not have any gloves. CW1 asked if he was okay, but the AP did not answer. The AP opened his eyes and looked at CW1. CW1 noted he was breathing and called 911. RCMP officers arrived about 10-15 minutes later. CW1 observed the interaction with the police. He noted the AP was unsteady on his feet and the officers seized vodka from him.

WO1, WO2, and WO3 attended the scene. When they arrived, they located CW1 and the AP. They noted that it was clear the AP was impaired as he was struggling to stand up, had a strong smell of alcohol on his breath, had slurred speech and glossy eyes. Based on his behaviour, WO3 assumed the AP had consumed a significant amount of alcohol prior to police arrival. WO1 placed the AP under arrest for being intoxicated in a public place. He searched the AP and found a small pint of vodka, which was opened.WO3 noted the bottle was about ¾ full. The AP was placed in the back of the police vehicle. WO1 attempted to obtain an address or phone number for a family member from the AP, however he was unable to do so, and transported the AP to the detachment.

Digby Detachment

Once the AP arrived at the detachment he was processed and placed into cells. According to the booking document and video, the AP did not indicate he had any medical issues. WO1 checked on the AP's sobriety and stated, "he seemed to be on a road to sobriety". WO1 also attempted to find a phone number to call someone who could pick up the AP so he could be released from cells. He located a number for a family member, but was unable to reach them.WO2 observed the AP while WO1 attempted to contact a family member. During this time, the AP was knocking on the cell window. Witness Officer #4 (WO4) arrived at the detachment for night shift and relieved WO2 from watching the AP. During his observation he noted the AP was laying on the bench and got up to vomit in the toilet a few times, which caused WO4 to ask WO3 if this was a case of alcohol poisoning, but they did not believe so. WO4 observed the AP for about 15 minutes until the civilian guard (Civilian Witness #2/CW2) arrived and took over observation. WO4 provided information about the AP's arrest and observations while in cells to CW2. CW2 advised she would keep a close eye on him.

WO4 stated that he and other officers had discussed whether the AP could be released and whether he had a place to go with another sober adult. They were trying to assess whether it was safe to let him go or whether he still needed to be held. Witness Officer #5 (WO5) noted that the weather

was considered when they were making the decision to keep the AP in cells. During the overnight/early morning hours of February 11th, the temperature dropped to -17 degrees Celsius. WO5 stated the officers determined if he was intoxicated, it would be safer for the AP to stay in cells until he became sober.

CW2 stated she was working as a guard at the Digby RCMP detachment on the day of the incident. She received a call around 4:00 pm to attend Digby cells and advised she could arrive by 5:00 pm. When she arrived, an officer was guarding the AP. She was informed the AP was intoxicated and vomiting. During her shift, she conducted checks on the AP and noted he had vomited a couple of times. She went to his cell door and provided him with water and toilet paper. She stated the AP was laying on the bench but was turning back and forth on his left and right side. He also got up a few times to go to the toilet. There was one incident (which she recalled being at the beginning of her shift) where the AP was using the toilet and he collapsed. CW2 dropped everything and ran to the cell to see if he was okay. The AP responded he was and laid back on the bench. CW2 continued to watch him to make sure he was breathing. She noticed his toes were moving. She also advised at 11:30 pm the AP asked if he could go outside to smoke. She had a conversation with him explaining she was not allowed to take him out. During that time, she noted he was wobbly and still seemed to be intoxicated. WO4 stated he had a conversation with CW2 partway through her shift while she was getting coffee. He asked about the status of the AP, and she said he was doing okay and had been sleeping for the last few hours. She also stated he was tossing and turning. CW2 stated she did not have any concerns for the AP's health, with the exception of the time he fell in the cells, but noted he was communicating and moving after this occurred. She also noted when someone is vomiting in cells, they are trained to keep a closer watch on them.

CW2 finished her shift at 1:55 am on February 11, 2025. Civilian Witness #3 (CW3) was the civilian security guard who relieved her. He arrived at 1:45 am. CW2 provided him with an update that the AP had fallen down, was vomiting, and appeared to be intoxicated.

At 2:17 am, WO5 interacted with the AP. He stated it is policy for an officer on duty to sign off on the guard's logbook at the end of their shift. This was confirmed as part of the investigation. As part of this process, WO5 conducted a visual check on the AP. WO5 opened the cell sliding window and looked in. The AP looked at WO5. WO5 stated the AP looked confused and appeared to still be intoxicated. The AP was known to WO5, as he had dealt with him previously. He noted the cell smelled of vomit and he was aware that the AP had vomited on a few occasions. He stated this did not make him think there was any reason to be concerned about the AP as it is not abnormal for someone who is intoxicated to vomit. Additionally, he noted the vomit was in the toilet, which indicated the AP was able to move around and was cognitively aware that he had to get up and go to the toilet. He said this is different than someone who is laying on their back aspirating and

vomiting. He noted he did not see any injuries during his interaction. The AP looked like someone who had just woken up and was under the influence of alcohol.

CW3 stated he started his shift at approximately 2:00 am. When he took over observation from CW2, the AP appeared to be sleeping and moving in his sleep. CW3 observed the AP through the closed-circuit camera and conducted physical checks on him every hour. The AP stood up on three occasions to go to the toilet. CW3 noted the first two were uneventful, but the AP appeared to be unsteady on his feet on the third occasion (*Director's Note*: After reviewing the other evidence, I understand this incident to have occurred at approximately 7:00 am). When the AP backed up toward the bench, he caught his leg, fell back and hit is head on the wall. This was heard by CW3 and he attended the cell to check on the AP. The AP laid down and pulled his arms into his chest and did not appear to move.

Witness Officer #6 (WO6) attended the cells around 7:15 am to see if the AP was ready to be released. When he arrived, CW3 was standing next to the cell door and looking at the AP. CW3 explained the fall that just occurred to WO6. WO6 opened the cell door, called out to the AP, and tapped him on the chest to see if he could get a reaction or response. The AP did not respond. WO6 noted the AP's eyes were open and he was still breathing. However, due to the fact he was not responding he went to get WO1 and told him to call EHS. WO1 and WO6 remained in cells to monitor the AP until EHS arrived at 7:30 am.

Witness Officer #7 ("WO7") started his shift as WO1 was calling for EHS to attend. He stated when he attended the cell, the AP was unresponsive and laying on his back. He assisted in moving the AP up on the bench and placed his hand on the AP's chest to see if he was breathing. He noted the AP's chest was rising and his eyes were moving around. Since there were officers in the cell dealing with the AP and WO7 then monitored from the guard station. He advised that once EHS showed up CPR was started, and the AP was moved to the floor. The paramedics continued CPR for a number of cycles, with two officers stepping in to assist when needed. Once the decision was made to transport the AP to hospital, he was placed on a stretcher and CPR continued as the AP was being placed in the ambulance. WO7 stated he did not observe any blood until EHS was doing CPR. When the AP was being transported out of the cell, he noted that blood was coming from his mouth. He did not observe any injuries on the AP.

The paramedics (Civilian Witnesses #4 and #5/CW4 and CW5) noted the AP was unconscious with a pulse. The pulse remained for 10-15 minutes while assessing him before the AP stopped breathing. CPR was started on the AP and WO1 and WO6 assisted the paramedics. EHS decided to transport the AP to hospital, and they left the detachment at approximately 8:00 am (according to WO1, this was when the hospital opened). WO6 noted when he first arrived in the cell, he only

observed a bruise above the AP's right eye. After the paramedics arrived and compressions were started WO6 noticed there was blood in the cell that was coming from the AP's mouth. WO1 confirmed there was no blood in cells prior to the arrival of the paramedics. CW5 (a paramedic) confirmed the AP had blood coming from his mouth, which required to be suctioned.

WO1 followed EHS to the hospital in his police car. They left the detachment at 8:03 am and arrived at 8:05 am. When they arrived, he assisted EHS in taking the AP to the trauma room where the nurses took over. The AP was pronounced deceased at 8:46 am. At the hospital, WO1 was advised the AP's bleeding was the result of a gastrointestinal bleed. WO1 stated the doctor advised him that there was nothing that could have been done differently to change the outcome.

Cell Block Footage and Body Worn Cameras

A number of witness officers were wearing body worn cameras during their interaction with the AP. The statements and notes provided to SiRT are consistent with the body worn camera footage. Cell Block footage was also obtained, which captures the AP's movement in cells. The video footage obtained in the course of the investigation confirms the following timeline:

AP enters the cell at 4:05 pm and is monitored by WO2. The AP is observed sitting up, moving to the cell door and the toilet and vomiting. WO4 replaces WO3 at 4:47 pm. The AP is observed vomiting in the toilet three times prior to the arrival of CW2 at 4:58 pm. Between 4:58pm and 1:47 am, CW2 looks into the cell window twelve times. At 11:50 pm, the AP falls and hits his head on the wall, hits the side of the toilet, and falls on the floor. CW2 goes to the cell and communicates with the AP. At 1:49 am, CW3 arrives. CW2 and CW3 talk before CW2 leaves the cell area. At 1:57 am, CW3 looks into the cell window. At 2:16 am, WO5 looks into the cell window and signs the logbook. Between 4:29 am and 6:59 am the AP is observed moving within the cell. At 7:00 am, the AP hits his head on the wall after struggling to get up from the toilet. He falls seated on the bench and struggles to get upright. He falls backwards with his arms by his upper torso. At 7:02 am, CW3 walks to the door to observe the AP and returns to his desk at 7:06 am. The AP is observed moving his arms at 7:01 am and 7:10 am. At 7:15 am, CW3 returns to the cell door to observe the AP and WO6 attends the cell. WO6 enters the cell, then leaves. He returns at 7:18 am with WO1. An officer remains in the cell with the AP. WO1 checks the AP's pupils at 7:21 am. At 7:27 am EHS enters the cell area, and they depart at 8:04 am.

Autopsy of AP

On February 12, 2025, a postmortem examination was performed on the AP. It was determined the AP's cause of death was an "upper gastrointestinal hemorrhage due to chronic ethanol use." It was determined the manner of death was natural.

AP Background

In the course of the investigation, SiRT learned that officers had interacted with the AP under similar circumstances a few months prior. The investigation determined that the AP had attended a local bar earlier in the day on February 10, 2025, where he consumed alcohol. He eventually left in a taxi at 2:20 pm. Approximately an hour later he is observed on video footage outside the local mall. He appears to have difficulty walking and falls into the snow. CW1 is observed at 3:15 pm to assist the AP.

Prisoner Logbook

The prisoner logbook was seized as part of the SiRT investigation. The entries in the logbook were made by CW2 and CW3. They are consistent with the cell block footage and statements provided.

Guarding Prisoner Policies

SiRT obtained the RCMP Guarding Prisoner's Policy and policies related to the Digby Detachment as part of the investigation. They outline the role of Guards and Members when monitoring someone who is in custody. There are also policies on assessing responsiveness of an individual in custody and protocols for when medical assistance is required. The policies also state that those individuals who are intoxicated shall be monitored more frequently.

RELEVANT LEGISLATION

***Criminal Code*:**

Duty of persons to provide necessaries

215 (1) Every one is under a legal duty

(a) as a parent, foster parent, guardian or head of a family, to provide necessaries of life for a child under the age of sixteen years;

(b) to provide necessaries of life to their spouse or common-law partner; and

(c) to provide necessaries of life to a person under his charge if that person

(i) is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and

(ii) is unable to provide himself with necessaries of life.

Offence

(2) Every person commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse to perform that duty, if

(a) with respect to a duty imposed by paragraph (1)(a) or (b),

(i) the person to whom the duty is owed is in destitute or necessitous circumstances, or

(ii) the failure to perform the duty endangers the life of the person to whom the duty is owed, or causes or is likely to cause the health of that person to be endangered permanently; or

(b) with respect to a duty imposed by paragraph (1)(c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.

Criminal negligence

219 (1) Every one is criminally negligent who

(a) in doing anything, or

(b) in omitting to do anything that it is his duty to do,

shows wanton or reckless disregard for the lives or safety of other persons.

Definition of *duty*

(2) For the purposes of this section, ***duty*** means a duty imposed by law.

Causing death by criminal negligence

220 Every person who by criminal negligence causes death to another person is guilty of an indictable offence and liable

(a) where a firearm is used in the commission of the offence, to imprisonment for life and to a minimum punishment of imprisonment for a term of four years; and

(b) in any other case, to imprisonment for life.

LEGAL ISSUES & ANALYSIS

I must now assess the evidence to determine whether there are reasonable and probable grounds to believe a criminal offence has been committed. Reasonable and probable grounds is a standard lower than a balance of probabilities or beyond a reasonable doubt, and more than reasonable suspicion.

Section 215 of the *Criminal Code* sets out when someone has a legal duty to provide another person with the necessaries of life. Section 215(1)(c) deals with a person who has the charge of another person who is unable to provide the necessaries of life to themselves. This includes people who are in police custody. Caselaw has found that a failure to provide medical treatment can amount to "necessitous circumstances" and lead to criminal liability. The offence is established, in part, on conduct that amounts to a marked departure from the level of care that a reasonable person would have exercised in the circumstances. A police officer's subjective belief that a person did not require medical attention is not a lawful excuse; however, the standard to be applied is that of a reasonable person in the shoes of the officer.

For criminal negligence, there must be a marked and substantial departure from what a reasonably prudent person would do in the circumstances. Criminal negligence requires proof of a wanton or reckless disregard for the life of another person.

At the time of the incident, the AP was lawfully in custody of the police for being intoxicated in a public place. While efforts were made to have him released to a family member, they were unsuccessful. Due to the AP's level of intoxication and consideration of the weather conditions that night, the decision was made to keep the AP in cells until he was sober, and it would be safe to release him.

The officers who interacted with the AP upon arrest all stated he was showing signs of intoxication. During the booking process, the AP did not indicate that he had any medical issues. After the AP was placed in cells he vomited on several occasions. The officers concluded this was a result of him being significantly intoxicated. The initial officers made sure to advise the civilian guard (CW2) of their observations, specifically that the AP was vomiting. CW2 advised she would keep a close eye on the AP.

RCMP policy states that when dealing with intoxicated persons, they should be observed frequently. From the time the AP was placed in cells at until EHS arrived on scene, a police officer or civilian guard was monitoring him. Additionally, one of the witness officers stated there was a policy for an officer to sign off when a civilian guard changes shift. In this case, an officer attended

the cells and conducted a visual check on the AP. Merely following policy is not a defence for criminal conduct, however it does outline what is expected of officers in their role.

The actions of the officers fell within the expected behaviour of a police officer. While they knew the AP was intoxicated, there is no evidence to suggest that the officers knew or ought to have known the AP was in medical distress or suffering from a medical condition before EHS was contacted. The AP was moving around the cell throughout the night and had conversations with CW2. Even though the AP was vomiting and unsteady on his feet, there was no evidence to suggest to them that this was related to anything but intoxication. Additionally, when the AP fell during the night, he was checked regularly to ensure he was moving and able to communicate. There was nothing notable or concerning about the AP's behaviour until early the following morning.

When the AP fell in the morning (7:00 am) and hit his head on the wall, CW3 attended the cell door to observe the AP. When an officer arrived shortly after, CW3 advised him of the fall. The officer immediately entered the cell to check on the AP. The AP was still breathing but unresponsive. EHS was contacted immediately, and officers remained with the AP until they arrived. The officers also assisted the paramedics in administering CPR.

I have also noted the AP's cause of death was "upper gastrointestinal hemorrhage due to chronic ethanol use." The AP's cause of death was not related to something that happened while in cells. Considering the circumstances and observations made of the AP, it was not reasonable for the officers to know or foresee that the AP would go into medical distress. I cannot find there was a marked and substantial departure from what a reasonable person would do in the circumstances.

Based on the totality of the evidence there are no reasonable grounds to believe the RCMP officers committed a criminal offence. There were two civilian guards who interacted with the AP during his time in cells. The *Police Act* does not grant SiRT jurisdiction to investigate civilian guards who are not special constables. However, the investigation did not find any evidence to indicate any criminal wrongdoing by the civilian guards which would warrant a referral to the police for an investigation.

CONCLUSION

After a careful review of the evidence and the law, I have determined that there are no reasonable grounds to believe a criminal offence was committed in relation to the AP's tragic death. This was an unfortunate set of circumstances and SiRT sends its condolences to the family.