INDEPENDENT
Investigations Office of BC

IN THE MATTER OF THE DEATH OF A MALE WHILE IN THE CUSTODY OF THE RCMP IN THE CITY OF PENTICTON, BRITISH COLUMBIA ON AUGUST 16, 2018

DECISION OF THE CHIEF CIVILIAN DIRECTOR OF THE INDEPENDENT INVESTIGATIONS OFFICE

Chief Civilian Director:	Ronald J. MacDonald, Q.C.
General Counsel:	Clinton J. Sadlemyer, Q.C.
IIO File Number:	2018 – 102
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Facts

On August 16, 2018 at approximately 7:05 a.m., Officer 1 made a routine traffic stop of a vehicle that the Affected Person (AP) was driving. During the stop, AP's name was checked and AP was found to have an outstanding arrest warrant. Officer 1 arrested AP, took him to the Penticton detachment and AP was lodged in cells to await transport to Court. At approximately 9:19 a.m., Sheriffs 1 and 2, who were to transport AP to Court, found that AP was not breathing. CPR was commenced and AP was taken by paramedics to hospital where he was pronounced deceased at 10:16 a.m.

The Independent Investigations Office (IIO) was notified by the RCMP at 10:40 a.m. and commenced an investigation because AP died while in the care of the police.

Evidence collected during the investigation included the following:

1) Occurrence report of Officer 1;
2) Statements of Sheriffs 1 and 2;
3) CCTV from the RCMP detachment;
4) Cell block records;
5) Computer Assisted Dispatch (CAD) records;
6) Photographs; and
7) Attendance at the autopsy.

Officer 1 reported that at 7:04 a.m. he was in his police vehicle and observed AP committing a traffic violation. Officer 1 reported that he pulled AP over and, while interacting with AP, checked his name. Officer 1 was advised that AP had an outstanding warrant for his arrest and he took AP into custody. Officer 1 reported that he allowed AP to move his vehicle to a safer location. AP requested and was permitted to bring his medication. Officer 1 transported AP to the Penticton detachment.

CAD records reflect that Officer 1 electronically recorded that he was transporting AP from the location of his vehicle to the detachment between 7:35 a.m. and 7:39 a.m.

Once at the detachment, AP's movements were continuously recorded by CCTV, from the time he and Officer 1 arrived in the secure bay at 7:39 a.m. until AP was taken out of his cell by paramedics at 9:58 a.m. On his arrival at the detachment, AP can be seen on the CCTV walking unassisted and without difficulty:

- while he was being booked in;
- during his telephone call to counsel;
- while he was fingerprinted; and
- when he was put into a cell.

Cell block records coincide with AP's movements seen on the CCTV.

The only physical contact between AP and Officer 1 that is seen on CCTV was when handcuffs were removed and during the fingerprinting process.

AP was then given access to his medications and secured in a cell. Cell block records also confirm that AP was provided with his medication.

CCTV shows AP entering a cell and shortly after being provided a meal. CCTV shows AP laying down on his left side, sitting up and shortly thereafter, at 9:10 a.m., again laying down. Cell block records reflect that AP was checked and observed at appropriate intervals during this time. The records also indicate that Sheriffs arrived shortly after 9:00 a.m. and three other individuals were removed from cells for transport to Court before Sheriffs entered AP's cell at 9:19 a.m.

CCTV shows Sheriff 1 enter AP's cell and when AP did not immediately rouse Sheriff 1 left and returned with Sheriff 2. Sheriffs 1 and 2 quickly commenced and continued CPR until 9:29 a.m., when paramedics arrived and took over.

CCTV shows AP being placed on a gurney and taken out of the cell.

AP was transported to hospital and was pronounced deceased at 10:16 a.m.

Except for CPR, no physical force was used at any time during AP's presence in the detachment.

An autopsy was performed with IIO investigators present. No physical trauma beyond what was consistent with CPR was noted. The pathologist found that AP's heart was enlarged and that his arteries in his heart were significantly obstructed. The pathologist was of the opinion that the cause of death was heart disease.

Relevant Legal Issues and Conclusion

The purpose of any IIO investigation is to determine whether an officer, through an action or inaction, may have committed any offence in relation to the incident that led to the injury to AP.

In this case, Officer 1 was under a duty to arrest AP who was cooperative throughout the process. Officer 1 appropriately permitted AP to retrieve his medication from his vehicle. There is no evidence that AP was mistreated in any way. Officer 1's report is consistent with CAD and cell block records. Finally, there is no evidence that Officer 1 either did, or failed to do, anything that may have caused AP's death.

This is an unfortunate situation where AP's health caused his death during the short period of time he was in custody awaiting his attendance in court. The autopsy confirmed there was no trauma suffered by AP, other than would be expected from lifesaving measures, and that his death was caused by heart disease.

It would appear his death was inevitable and, although it may be that the stress of his arrest aggravated the situation somewhat, Officer 1 was acting entirely lawfully and appropriately throughout.

The evidence collected does not provide grounds to consider any charges against any officer. Officer 1 acted as required by his duties and in accordance with the law.

Accordingly, as the Chief Civilian Director of the IIO, I do not consider that an officer may have committed an offence under any enactment and therefore the matter will not be referred to Crown counsel for consideration of charges.

Clinton J. Sadlemyer, Q.C.
General Counsel

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Chief Civilian Director

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