PUBLIC REPORT OF THE CHIEF CIVILIAN DIRECTOR

Investigation into the November 13, 2012 death of an adult male involving a fatal self-inflicted injury and the Vancouver Police Department, in the city of Vancouver, British Columbia.

IIO 2012-11-179

INTRODUCTION

The Independent Investigations Office (IIO) is responsible for conducting investigations into all officer-related incidents which result in death or "serious harm" (as defined in Part 11 of the Police Act) within the province of British Columbia. As the Chief Civilian Director of the IIO (CCD), I am required to review all investigations upon their conclusion, in order to determine whether I "consider that an officer may have committed an offence under any enactment, including an enactment of Canada or another province." (See s.38.11 of the Police Act). If I conclude that an officer may have committed an offence, I am required to report the matter to Crown counsel. If I do not make a report to Crown counsel, I am permitted by s.38.121 of the Police Act to publicly report the reasoning underlying my decision.

In my public report, I may include a summary of circumstances that led to the IIO asserting jurisdiction; a description of the resources that the IIO deployed; a statement indicating that the IIO, after concluding the investigation, has reported the matter to Crown counsel; or a summary of the results of the investigation if the matter has not been reported to Crown.

I am only permitted to disclose personal information about an officer, an affected person, a witness, or any other person who may have been involved if the public interest in disclosure outweighs the privacy interests of the person. Prior to disclosing any personal information, I am required, if practicable, to notify the person to whom the information relates, and further, notify and consider any comments provided by the Information and Privacy Commissioner (s.38.121(5) of the Police Act).

In this case, I have considered all of the factors and will not be disclosing the identities of the affected person or any other person. The affected person was 33 years old at the time of his death.

CIRCUMSTANCES LEADING TO NOTIFICATION TO THE IIO

On November 13, 2012, at 10:31 a.m., officers in the employ of the Vancouver Police Department (VPD) were dispatched to assist the Vancouver Fire Department (VFD) and paramedics from BC Ambulance Services (BCAS) in responding to a dropped 911 call.

In response to the dropped call, the 911 operator referred the follow up to a Burnaby RCMP dispatcher who subsequently called the originating number. A male answered and initially stated he had been the victim of prank calls. When questioned by the dispatcher, he then indicated he needed an ambulance for "stuff" and finally stated he was having a "heart attack". The dispatcher was concerned about the male's responses and requested that police attend the scene prior to BCAS.

When the first VPD officer arrived at the scene, he saw that the VFD had already responded to the possible heart attack call and had made contact with a distraught male. The male was confirmed to be the original 911 caller. The male was at the front door of his residence; he was holding a large butcher knife and had significant and visible injuries.

Over the following minutes, attempts were made by police to have the male drop the knife so that first aid could be rendered. These attempts were unsuccessful.

At 10:40 a.m., an officer deployed a Conductive Energy Weapon (CEW, commonly referred to as a Taser) and subsequently, the male was subdued. He was restrained and then treated by fire fighters and paramedics.

He was transported to hospital however did not survive his injuries. According to the BC Coroners Service, he was pronounced deceased at 11:31 a.m.

NOTIFICATION AND IIO JURISDICTION

The IIO was notified of the incident by the Vancouver Police at 11:13 a.m. and asserted jurisdiction based on the male's critical injuries and the report of the "use of force."

INVESTIGATIVE EVIDENCE CONSIDERED

There were numerous witnesses to the incident including members of the Vancouver Police and Fire Departments, media at the scene, BC Ambulance Services (BCAS) paramedics, the man's roommate, civilian witnesses at the scene and those identified through a neighbourhood canvas.

Members of the VFD were first on the scene. They provided voluntary statements to IIO investigators.

When they arrived, the male was observed standing at the open front door of the residence holding a large knife towards himself. He had cuts to his neck and was bleeding.

A VFD supervisor was the first fire fighter to make contact with the male. The supervisor noted the man was armed with the knife, and was trying to "stab" himself in the chest. He stated: "and as he pulled his hand out again to do it again, there was the blade. And I thought- it's a real knife, cause I could see the stainless steel. And I yell at him, don't do that, don't do that. I don't know how many times I yelled it."

The supervisor requested an emergency response by VPD advising dispatch “this man is trying to kill himself”. He advised he heard the male yelling at an officer to “shoot me in the head”. The officer responded with “I’m not going to shoot you in the head. We’re here to help you. Put the knife down”. The VFD supervisor later witnessed the deployment of the CEW and the male’s self-inflicted cut to his throat. Other VFD witnesses provided accounts of their observations that were consistent with the supervisor and other witnesses.

Three officers from the VPD were identified as “subject officers”: the first officer on the scene; the second officer who deployed the CEW; and a third officer who assisted in restraining the male. The subject officers all made “duty reports” but did not make warned statements to the IIO.

Other VPD officers identified as witnesses provided compelled statements. These witnesses provided consistent accounts of the events leading up to and including the final deployment of the CEW.

One witness officer stated she was present at the time of the first CEW deployment and that it did not appear to be effective. She observed the male looked “like he was pushing (the knife) forcefully into his neck”.

Another VPD witness officer stated she saw several fire fighters in the yard when she arrived on the scene. The male was in the doorway holding a knife to his chest. She noted he had blood on his shirt and that he was bleeding from the neck. She witnessed the CEW being deployed and that after the second deployment, the male fell into the living area of the residence.

A third VPD witness officer stated that after the male fell, her primary focus was to locate and secure the knife. It was located in the residence about five feet from the male. She observed the other officers trying to restrain the male using handcuffs and noted that although bleeding heavily, he continued to resist. She stated: “he was trying to fight off the members…he was trying to fight the paramedics, he was just trying to fight just anybody off”.

BCAS paramedics also provided voluntary statements. The Advanced Life Support Unit had been dispatched to the location and at 10:29 a.m., was “staged” a block away until police could secure the scene. Once the male was restrained, they were advised that it was safe to proceed to the scene. Paramedics entered the residence and took over the medical response.

One paramedic recalled that while he was trying to treat the male, “he was fighting against the handcuff”. Another stated that the male was still struggling as a fire fighter “was trying to hold direct pressure on (his) bleeding neck”.

The CEW was seized and evaluated to ensure it was operating according to the manufacturer's specifications. The data from the device was downloaded. It was determined that the device was deployed once then re-loaded. It was subsequently deployed a second time. Based on the review of the data, it appears that the first deployment was unsuccessful. The second deployment resulted in two separate cycles of the CEW for a total of ten seconds over a 13 second period of time.

IIO investigators obtained a video recording held by a lower mainland media outlet that showed the VPD officer after the first deployment, re-loading the CEW with a new cartridge. The recording also showed the male cutting his throat as well as the second CEW deployment.

A second video of the incident was provided by a civilian witness; this video provided contemporaneous narration of the event. The civilian witness can be heard on the video: "they tasered him…they just tasered him, he tried to commit suicide, he cut himself with a knife, now the police and paramedics are rushing in".

IIO investigators obtained photographs of the scene and documented additional evidence. This included evidence of substantial blood loss by the deceased and that of two separate CEW deployments.

An autopsy was conducted on the deceased on November 16, 2012. His death was attributed to "sharp force injury to the neck" with significant blood loss and secondary injury to the abdomen. Toxicology indicated the presence of methamphetamine and amphetamine.

ISSUES

The general issue in this case is whether or not there is evidence that a police officer may have committed an offence under any enactment. The specific question I must consider is whether or not the involved officers committed an assault on the deceased by means of the CEW, and/or criminal negligence while taking him into custody.

In considering the potential offence of Assault with a Weapon, I must review the circumstances in the context of both the Criminal Code s. 25 (1) and the Mental Health Act, RSBC 1996, Chapter 288.

In considering the potential offence of criminal negligence: criminal negligence is defined in s. 219 of the Criminal Code and reads as follows: "Everyone is criminally negligent who (a) in doing anything, or (b) omitting to do anything that it is in his duty to do, shows wanton or reckless disregard for the lives or safety of other persons."

In addition to those potential offences, I need to consider the issues raised by counsel for the BC Civil Liberties Association (BCCLA), namely whether the use of the CEW contributed to the death in any way. Further, I need to consider their additional questions on whether the deployment of the CEW could have caused additional injury to the deceased e.g. by causing him to fall on his knife.

REASONS and DECISION of the CHIEF CIVILIAN DIRECTOR

I have considered the investigation report and file, and the principles underlying criminal liability with respect to criminal negligence. I have concluded that there is no reason to consider that any police officer may have committed an offence.

Based on my review of the facts, I am satisfied that the deceased died of self-inflicted injuries he sustained on November 13, 2012. These injuries occurred when the deceased used a knife on his abdomen and neck. The classification of death remains the jurisdiction of the Chief Coroner however the cause of death (sharp force injury) was established at autopsy.

While it would have been helpful to have received warned voluntary statements from the subject officers, as evidence of their subjective intent, all the other evidence provides no grounds for me to consider that they committed any offences. Given the videos, the CEW data and available witness statements, I am satisfied that officers did everything they could to prevent the deceased from harming himself any further.

With regard to the potential offence of Assault with a Weapon, in my view, the officers were authorized to arrest the deceased under s. 28 of the Mental Health Act. To administer s.28 of the Act, the officers were justified under s. 25 (1) of the Criminal Code in using necessary but not excessive force. In my view, the use of the CEW was not excessive force given the circumstances of the case. The decision to cycle the CEW for a second time, in my mind, was a reasonable decision made to disarm an individual who was suicidal and presented a danger to himself and others, and to ensure he received medical aid.

Officers eventually were able to restrain the male. The handcuffing was in order to ensure that he could do no further harm to himself or to others who were providing medical assistance and cannot be concluded to be criminally negligent. This set of circumstances presented a substantial safety risk to the man and to first responders. I have considered the options and am satisfied that no other less lethal means of subduing and restraining the man were viable.

As an additional note, the IIO will not release the video tape of the incident as part of the public report. Due to the graphic nature, it is my view that the video would harm the deceased's right to privacy, could cause irreparable harm to his family and friends and is not suitable for public dissemination.

I have directed that notice of this public report be provided to the Vancouver Police Department, the Vancouver Fire Department, BC Ambulance Services, the BC Coroners Service and the Office of the Police Complaint Commissioner, as each may have an interest in this investigation and my findings in that regard. I have further directed that this report be posted to the Independent Investigations Office public website in order to ensure transparency through public reporting.

This public report was derived from a reviewable decision made by myself, Chief Civilian Director Richard Rosenthal. A copy of the reviewable decision is available upon request.

Submitted this 25th day of February, 2013 by

Richard A. Rosenthal
Chief Civilian Director
Independent Investigations Office of BC