



PUBLIC REPORT OF THE

CHIEF CIVILIAN DIRECTOR

Regarding the September 9, 2013 death of
an adult male involving the RCMP in
Smithers, British Columbia

IIO 2013-000050

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 Counsel.

This is a public report related to the investigation into the death of an adult male that occurred on September 9, 2013, in Smithers. The affected person died from self-inflicted sharp force injuries shortly after his release from RCMP custody.

Pursuant to s.38.11 of the *Police Act*, RSBC 1996 Chapter 367, I have reviewed the concluded investigation. I do not consider that any officer may have committed an offence under any enactment and will not be making a report to Crown Counsel.

In my public report, 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 the advice provided by the Information and Privacy Commissioner. I will not be disclosing names of any persons involved.

The affected person was 25 years old at the time of his death.

NOTIFICATION AND JURISDICTION DECISION

The RCMP notified the IIO shortly after the incident on the day it occurred. Jurisdiction was asserted in order to determine whether the affected person’s death occurred as a result of any action (or failure to act) on the part of a police officer in British Columbia.

EVIDENCE CONSIDERED

IIO investigators interviewed police officers and a civilian cellblock guard. Video evidence from the RCMP cellblock and the retail location at which the affected person sustained his injuries was reviewed.

A toxicology report was reviewed and a visual examination of the affected person's body was conducted.

GENERAL TIMELINE

On September 9, 2013, at 2:35 a.m., the affected person telephoned the Smithers RCMP to report that he was hiding in a house and alleged that there was a group of people there who were going to cause harm to him. Officers were dispatched at 2:40 a.m., and arrived at the scene by 2:46 a.m. The officers transported the affected person to a local hospital for assessment, where they arrived at 2:56 a.m.

According to Witness Officer 1 (WO1), the affected person was released from the hospital at approximately 5:15 a.m. and was not further detained by the responding officers.

At 5:23 a.m., the Smithers RCMP received a call from an employee of a gas station, located a short distance from the hospital. The caller indicated that a male (later determined to be the affected person) was throwing objects around. A second call was received from the gas station at 5:30 a.m., inquiring when police would be arriving. Subject Officer 1 (SO1) and Subject Officer 2 (SO2) arrived at the gas station at 6:03 a.m. By 6:17 a.m., they located and arrested the affected person a short distance from the gas station. The affected person was held in a detachment cell until approximately 2:47 p.m. that same day. He ultimately left the detachment at 2:58 p.m.

At 3:01 p.m., the RCMP received a call from a store near the detachment, reporting that a man, (subsequently identified as the affected person), had sustained self-inflicted sharp force injuries inside the store. The affected person was treated by paramedics and transported to a local hospital, where he was pronounced deceased at 4:35 p.m.

STATEMENTS OF POLICE OFFICERS

Subject Officer 1 provided a voluntary statement to the IIO. Subject Officer 2 consented to the IIO reviewing his Duty to Report however declined to provide a statement as is his right under the *Charter of Rights and Freedoms*.

SO1 stated that he was called to assist SO2 with a male who was yelling and smashing things at a gas station. Since he had to respond from home, it took approximately 45 minutes to respond to the call. When they got to the gas station, the male had already left. They patrolled the area and located the affected person, who matched the description provided by witnesses. SO1 was familiar with the affected person and noted that "something seemed off." The officers explained they were there because of a complaint from the gas station and subsequently arrested the affected person for "mischief." He was transported to the detachment and placed into a cell sometime between 7:00 a.m. and 7:15 a.m.¹ The affected person expressed no suicidal ideation during his interaction with SO1.

Later that day, at 2:50 p.m., SO1 was advised by a civilian guard that SO2 was having difficulty removing one of the prisoners from the cell block. SO1 attended the cell block and saw the affected person standing in a cell. SO2 told the affected person that he had to leave. The affected person walked out of

¹ Cell video established that the actual time that the affected person was placed into a cell was at 6:20 a.m.

the cell and out of the door of the detachment. SO2 told SO1 that the affected person had previously left the detachment, but had returned back to his cell.

SO1 followed the affected person outside. He noted that the affected person was “still acting odd,” but had not spoken a word. He saw the affected person walk out to the parking lot, turn around and look back. The affected person then began running toward a store near the detachment.

Within one to two minutes, SO1 received a call for police to respond to a store as someone had reportedly tried to harm himself with a knife. SO1 arrived within 20-30 seconds of the call and ran into the store. He saw the affected person lying on the ground receiving medical attention from an off-duty nurse. SO1 assisted the nurse in communicating with the hospital emergency room, but noted that the affected person lost a significant amount of blood prior to the arrival of emergency medical personnel.

Subject Officer 2 reported that at 2:47 p.m., he released the affected person from custody. He reported that the affected person was acting strangely. He reported that he asked the affected person what was wrong “a couple of times,” but the affected person would not respond. SO2 reported that he told the affected person that if he did not say anything, he could not help him. The affected person said: “they’re there.” SO2 asked for clarification. The affected person replied “the males in the truck, they’re going to hurt me.”

SO2 reported leaving the building and walking around the corner, but not seeing anyone near the detachment. The affected person then walked along the side of the building before he ran back into the detachment.

SO2 again asked the affected person “what was up” and he replied “they’re around the corner.” SO2 checked again, but saw that no one was there. The affected person walked back into the detachment cell area and stated “can’t leave.” SO2 reported that he explained to the affected person that he could not help if he chose not to talk and that there was nothing he could do. The affected person refused to say who the people were and would not say anything more. SO2 put the affected person back into his cell and checked around the detachment again, but found no one. SO2 and SO1 then advised the affected person that he would have to leave and observed him exit the detachment.

SO2 reported that he considered detaining the affected person under the *Mental Health Act*, but did not believe he could do so as the affected person did not make any admissions or indications of intent to harm himself or anyone else.

Witness Officer 1 was interviewed by IIO investigators.

WO1 acknowledged responding to the first complaint from the affected person alleging that there were people outside of a residence wanting to hurt or kill him. He stated that he was afraid. WO1 and Witness Officer 2 (WO2) spoke to the affected person, who they found sitting on a low roof at the residence. She could see that the affected person’s whole body was shaking, and he was “very agitated and fidgeting.”

After handcuffing the affected person, WO1 put her hand on his left bicep and could feel “his heart pounding against the inside of her hand,” even through thick gloves. The affected person told her “I’m not going to make it this time” and expressed concern about his use of a drug.

After checking the residence to make sure there was no one presenting a threat, the officers drove the affected person to the hospital. WO1 asked the affected person if he was trying to hurt himself and he replied “no.”

According to WO1, while he being treated at the hospital, the affected person did not demonstrate any violent traits and no force was applied to him.

Witness Officer 2 was also interviewed by IIO investigators.

WO2 acknowledged responding to the initial call from the affected person. He also noted that the affected person was “out of it, bug-eyed, wandering around aimlessly – not sure of what he was doing.” He described the affected person as experiencing a state of “excited delirium.”

After checking the home to ensure all residents were safe, the officers decided to transport the affected person directly to the hospital. The trip took less than three minutes. The hospital requested that an officer remain with the affected person for safety reasons. As such, WO2 remained at the hospital until approximately 5:15 a.m., at which time the affected person was released.

Once the affected person was discharged from the hospital, WO2 walked him out of the emergency room doors and asked him what was going on. WO2 wanted to know more about the people that the affected person stated were coming after him. The affected person stated that he did not know who they were. The affected person stated that he wanted to go back inside the hospital and then to the cellblock as he felt a person or persons were going to harm him. WO2 did not believe he had any authority to take the affected person to the cellblock, nor did he observe any injuries that warranted further medical treatment. He did not see any indication of any intent by the affected person to hurt himself and the affected person made no comments to that effect.

CIVILIAN WITNESS

Civilian Witness 1 (CW1), a guard at the Smithers RCMP Detachment, was interviewed by IIO investigators.

According to CW1, he came on duty at 8:00 a.m. on September 9, 2013 and noted that the affected person had already been in cells and that everything seemed okay. The affected person looked intoxicated, but did not talk. CW1 noted that any time he walked by the cell door, the affected person would back away.

The affected person only spoke once to CW1, saying “They are going to kill me.” CW1 stated that he made several attempts during the day to converse with the affected person to see if there was something he wanted to say or get off his mind.

According to CW1, he was present when SO2 attended cells (later in the afternoon) to release the affected person. SO2 gave the affected person his belongings and asked him if there was something on his mind and if he wanted to talk. The affected person shrugged his shoulders. SO2 and the affected person then walked outside. CW1 followed a few minutes later. The affected person subsequently returned and looked like he was in a state of confusion. He walked or ran back inside the building followed by SO2 and CW1.

CW1 felt that the best thing to do was to put the affected person back in his cell to “cool down” for a short time. According to CW1, the affected person was later escorted to the door by SO1 and SO2. The last time CW1 saw the affected person, he was running from the detachment.

DETACHMENT VIDEO

Cellblock video showing the affected person’s period of incarceration in the Smithers Detachment was obtained and reviewed by the IIO.

The affected person was first placed into cells at 6:20 a.m. and was released at 2:58 p.m. on September 9, 2013. (This time was inconsistent with Subject Officer 1’s recall and statement however was determined to not be relevant.)

A review of the video evidence corroborated that at no time during this period did anyone enter the cell occupied by the affected person, nor was any type of physical altercation observed. The review of the video indicated no actions that would have caused any injury to the affected person during the time of his incarceration until his release from custody. The video was not clear enough to establish whether or not the affected person had sustained any injuries prior to his arrest and incarceration.

At 2:48 p.m., the affected person could be observed leaving his cell.

At 2:49 p.m., SO2 and CW1 could be seen returning the affected person’s belongings to him in the booking area of the detachment.

At 2:50 p.m., the affected person could be seen entering the vehicle bay of the detachment with SO2. SO2 could be seen standing at the open bay door with the affected person for 13 seconds.

At 2:51 p.m., the affected person could be seen exiting the building through the bay door. The affected person could then be seen returning to the bay door eight seconds later. Fourteen seconds thereafter, the affected person exited the building again, through the bay door, followed four seconds later by CW1.

Thirty seconds later, at 2:53 p.m., the affected person could be seen running back into the building through the bay door. He walked back into the cell and stood by the open cell door.

At 2:56 p.m., SO2 closed the cell door and left the building through the open bay door. SO2 returned to the detachment 26 seconds later.

At 2:58 p.m., the affected person was again released and walked into the bay area followed by SO1 and SO2. The affected person once again left the building, this time followed by the two officers. The officers returned to the bay door within 13 seconds and then 18 seconds later, left the building again, this time in the company of CW1.

The two officers and CW1 returned together to the bay door at 3:00 p.m., within 30 seconds of having left the building together.

RETAIL LOCATION VIDEO

Video evidence was also obtained from the store where the affected person sustained his self-inflicted injuries. The video showed the affected person rushing into the store and heading directly toward a display area. The affected person could be then seen approaching the cashier area holding a knife and subsequently cutting his throat.

PHYSICAL EVIDENCE

During a subsequent examination of the scene, a knife was found that appeared to have been obtained from the store by the affected person, immediately before he sustained his injuries.

MEDICAL EVIDENCE

IIO investigators did not obtain the confidential medical records relating to the affected person's treatment at the hospital immediately prior to his arrest for mischief. The affected person was clearly considered to be in a satisfactory state to be discharged by hospital staff. As such, the specifics of his treatment did not appear to be particularly relevant to the IIO investigation.

A toxicology report obtained by the IIO showed no evidence of cocaine, prescribed medication or alcohol. The toxicology report did show the presence of a metabolite of THC which is formed after cannabis is consumed.

An IIO forensic investigator and the assigned coroner examined the affected person's body on September 11, 2013. The IIO investigator noted sharp force injuries consistent with self-infliction and blunt force injuries consistent with the efforts of passers-by to restrain the affected person.

ANALYSIS

Everyone in Canada has a right to liberty, and the right not to be detained without just cause under the *Canadian Charter of Rights and Freedoms* s.7, s.9 and s.11(e). These principles obliged the police to release the affected person unless they had good reasons to deprive him of his liberty. Section 28 of the *Mental Health Act* provides that "[a] police officer or constable may apprehend and immediately take a person to a physician for examination if satisfied from personal observations, or information received, that the person (a) is acting in a manner likely to endanger that person's own safety or the safety of others, and (b) is apparently a person with a mental disorder."

At the point when Subject Officer 2 released the affected person, he had reason to believe, and according to him, did believe, that the affected person had a mental disorder. During his nine hours in the cellblock, the affected person made a number of unusual statements and asked to return to the cellblock, but he was reportedly not willing to provide sufficient information that would have allowed the involved officers to understand his mental state.

Subject Officer 2 wrote in his report that he “considered the *Mental Health Act* for the affected person, but considering he did not make any admissions or indications to harming himself or anyone else, that route was not taken.”

Given the available evidence, it does not appear that Subject Officer 2’s conclusion in this regard was unreasonable. The affected person’s actions prior to his incarceration did not involve any acts that could have been considered dangerous to himself or any other person. In addition, even though the affected person acted in an unusual manner, officers reported no evidence that he expressed intent to harm himself. Instead, it was reported that his only expressed concern was that others wanted to harm him.

There is no evidence that Subject Officer 2 would have been able to predict that releasing the affected person would have resulted in him harming himself. Therefore, I cannot conclude that Subject Officer 2 acted with “wanton and reckless disregard” for the affected person’s life or safety. As such, there is no reason to believe that Subject Officer 2 committed the offence of “Criminal Negligence.”

Even though a toxicology report did not show evidence of use of cocaine, as assumed by the officers who originally took him to hospital, such fact does not provide sufficient reason to disbelieve the officers’ conclusions that the affected person needed immediate medical attention. Although it is now impossible to determine the exact cause of the affected person’s physical and mental state at the time officers first made contact with him on September 9th, the officers appear to have acted appropriately in taking him to hospital for immediate treatment.

DECISION

Based on the evidence obtained during the course of this IIO investigation, I do not consider that any officer may have committed an offence in relation to the death of the affected person. Therefore the IIO file will not be referred to Crown Counsel for consideration of possible charges.

Prepared for release 25th day of February, 2014 by

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Independent Investigations Office of BC