INDEPENDENT
Investigations Office of BC

IN THE MATTER OF THE DEATH OF A FEMALE WHILE IN THE CUSTODY OF THE RCMP IN WHITE ROCK, BRITISH COLUMBIA ON MARCH 29, 2016

DECISION OF THE CHIEF CIVILIAN DIRECTOR OF THE INDEPENDENT INVESTIGATIONS OFFICE

Chief Civilian Director:	Ronald J. MacDonald, KC
IIO File Number:	2016-058
Date of Release:	May 7, 2024

THIS PAGE INTENTIONALLY LEFT BLANK

INTRODUCTION

On March 29, 2016, the Affected Person ('AP') died while in custody at the White Rock RCMP detachment. The Independent Investigations Office ('IIO') was notified and commenced an investigation.

An initial review of the evidence raised concerns about the conduct of a civilian jail guard tasked with monitoring detainees to ensure their welfare while in cells (a responsibility that includes calling for medical assistance as necessary), and also the conduct of attending paramedics. Since the IIO does not have investigative jurisdiction over jail guards in RCMP detachments or paramedics, the investigation of those individuals was referred to the Delta Police Department ('DPD') as a potentially criminal matter. The DPD investigation resulted in no charges being referred to Crown counsel.

Meanwhile, IIO investigators gathered evidence about the performance of duties by RCMP members who were responsible for the training and supervision of the civilian guards. A number of officers were designated by the IIO as subject officers on the basis of evidence suggesting they may be liable for offences of criminal negligence that may have been a contributory cause of AP's death.

At a certain point, though, analysis by IIO investigative and legal teams led the investigation in a rather different direction: while it was concluded that no individual officer could reasonably be held criminally responsible, the possibility of 'organizational criminal liability' had to be considered and investigated. The IIO investigation thus became a rather unique one, proceeding (with a number of difficulties and delays) over the following several years, as set out below.

NARRATIVE

Day One

On Friday March 25, 2016, at approximately 4:13 p.m., White Rock RCMP officers were dispatched to investigate a complaint regarding a female and male loitering in downtown White Rock. The female and male, later identified as the Affected Person ('AP') and her boyfriend, Civilian Witness 1 ('CW1'), fled on foot. Soon after, CW1 was arrested for breaching probation and an outstanding warrant, and AP was arrested by Witness Officer 1 ('WO1') on an outstanding warrant. WO1 asked AP when she had last used drugs and AP answered that she had last used "yesterday" and that she felt like she was "coming down with the flu". WO1 later told the IIO that AP did not appear "overly high" at the time of her arrest, and that she was very cooperative.

AP and CW1 were transported to the RCMP detachment. WO1 filled out a required prisoner report for AP, but failed to record her drug addiction. WO1 facilitated AP's call to Legal Aid duty counsel, and AP was then lodged in cells. WO1 noted that AP appeared "comfortable", and the officer stated she had no concerns about AP through the rest of that shift. AP was subsequently given a telephone bail hearing and was remanded in custody over the Easter long weekend until Tuesday, March 29 at 9:30 a.m.

Civilian Guard 1 (‘CG1’) was on shift from 4:30 p.m. to midnight. CG1 only worked at the detachment sporadically. He had never seen AP before, but told the IIO he believed he had been told that she was “a drug addict”. CG1 did not recall any medical issues during his shift. He stated that AP was restless, but he felt that “everyone” lodged in cells was restless.

IIO investigators reviewed cell block video recordings from the entirety of AP’s stay at the detachment. The CCTV does not record audio. In particular, investigators were able to view what happened in AP’s cell, in the hallway outside it, and in the Guard Room where the civilian guards sat and watched monitors showing detainees in their cells. Video from the evening of Day One does not appear to show AP being under any undue stress that evening: she ate, rested, and slept, as was confirmed by CG1’s notes in the Prisoner Log.

Day Two

AP was mildly restless through the night and into the morning of Saturday, March 26. CG2 worked from midnight to 8:00 a.m. He was familiar with AP and estimated she had been in cells five to six times over the previous eighteen months. CG2 knew her to be affected by drugs “always” and described her as being in “very bad shape […] basically skin and bones”. CG2 characterized AP as behaving as she normally presented – she rolled around, mumbled, and talked to herself. He recalled that her condition did not change during his shift.

CG3 worked 8:00 a.m. to 4:00 p.m. CG3 knew AP to be addicted to drugs and suffering from hepatitis C. He observed that AP slept for most of his shift. AP requested and was given an extra blanket. She ate lunch, consisting of pizza and a juice box. CG3 told the IIO AP was complaining that she didn’t want to attend court and that she wanted to go home. During his last check of AP before he finished his shift, CG3 said her eyes were closed and she was “raving”. Video shows AP lying down but restless, fidgeting, tossing and turning.

CG1 worked from 4:00 p.m. to midnight. He stated that AP seemed fine, and she was reasonably quiet. She continued to be restless, but he felt this was a common condition in cells.

At approximately 5:39 p.m., WO2 took AP to the phone room to speak to her legal counsel, CW2. CW2 later told the IIO that during their phone call, AP told him she felt ill. He said he replied that she could ask to see a nurse or doctor. When WO2 escorted AP back to her cell, AP told her she thought she was coming down with the flu and asked to see a nurse. WO2 told investigators that she confirmed with AP that she wanted to see a nurse, but AP then asked for Gravol instead. AP lay down in her cell and WO2 brought her antacid tablets, as there was no Gravol. WO2 told the IIO that she then told another officer, either WO3 or WO4, of her conversation with AP and that she had provided her with antacid. WO2 stated that she did not observe anything leading her to believe that AP needed medical attention.

According to the Cell Log (‘the Log’), AP declined dinner. CG1 wrote at 10:48 p.m. that AP was “going through withdrawals”; that she had been provided with apple juice; and that she had requested a change of clothes as she had wet herself. The video shows AP continuing to appear restless, shifting and turning over regularly throughout the night and into the next morning.

Day Three

The next morning, Sunday March 27, CG2 worked midnight to 8:00 a.m. At 12:51 a.m., CG2 noted in the Log that AP was yelling, “need a nurse”, but the video shows that he did not investigate. CG2 provided AP clean clothes at 1:00 a.m. At 4:25 a.m., WO1 conducted a cell check and noted the prisoners as breathing evenly. At 7:21 a.m., CG2 gave AP waffles, which she ate. According to the Log, there was nothing else noteworthy during CG2’s shift.

CG3 worked 8:00 a.m. to 8:00 p.m. At the beginning of his shift, he noted that AP used the toilet three times in close succession and wrote in the Log, “believed detoxing”. He recorded that at 9:33 a.m., AP was dry heaving. Shortly afterwards, she vomited in the toilet before returning to bed. At 10:45 a.m., she was moaning, and at 10:59 a.m., she vomited in the toilet again, then returned to bed. CG3 recalled in his IIO statement that AP did not eat lunch or dinner and only requested a juice box. CG3 observed her holding her stomach, indicating she was feeling unwell. Based on his training and experience, he said, CG3 believed AP was going through drug withdrawal. He said she rested quietly for the remainder of his shift.

CG2 came back on duty at 8:00 p.m. CG2 recalled that AP was drinking “quite a bit” of water, but that to the best of his recollection, he didn’t notice any change in her condition from his previous shift earlier that day.

Day Four

On Monday, March 28, at 12:34 a.m., CG2 noted in the Log that AP complained she was in pain and asked for medication. She was given another antacid and a cup of water. CG2 did not alert a police member to AP’s complaint. According to the Log and the video, AP rested quietly without event for the rest of the night and throughout the morning. She declined breakfast.

CG3 relieved CG2 at 8:00 a.m. AP also declined lunch. CG3 stated that at approximately 12:55 p.m. during a cell check, he observed that AP appeared ill, so he notified WO5. CG3 remained outside AP’s cell while WO5 opened the cell door to speak with AP. CG3 stated that AP said she thought she had the flu but did not want to be seen by EHS paramedics. WO5 told CG3 that AP was probably detoxing, and WO5 noted the conversation in the Log at 12:55 p.m., adding that AP wasn’t eating because she was sick, “likely from detoxing”. At this point, it had been just over 29 hours since AP last ate.

At approximately 1:06 p.m., CG3 stated he saw AP urinate on the floor by the cell door. He notified WO5, who stood by while CG3 cleaned up. WO5, in her written statement, recalled that when she asked AP why she had urinated on the floor, AP apologized and said she hadn’t made it to the toilet in time. WO5 then asked her if she might be detoxing from drugs, but AP said she hadn’t consumed drugs in “a long time”.

At 2:00 p.m., CG3 noted in the Log that AP was dry heaving. CG3 noted no other issues for AP before he finished his shift at 4:30 p.m., and guard CG1 started work. However, CG1 stated that when he came on shift, the guard leaving told him that AP had referred to him as “Doctor”. CG1 recalled that AP’s condition had changed in that she had become more incoherent; when he gave her water on one occasion, she also called him “Doctor”. CG1 stated that AP was not eating and was restless, but he was

aware that she was experiencing drug withdrawal and thought this was natural. He said that he did not have much experience with drug withdrawal and received no training on the subject.

The Log indicates that AP was drinking water directly from the tap when she was checked at 5:30 p.m. and again at 5:53 p.m. CG1 noted in the Log that WO3 conducted a cell check at 6:21 p.m. At 6:40 p.m., AP refused dinner. It was now over 35 hours since AP had last eaten. At 6:53 p.m., CG1 noted that AP was mumbling, then at 8:18 p.m. that she was mumbling about talking to a doctor, however CG1 did not take any action.

At 8:47 p.m., CCTV footage shows that AP crawled to retrieve a cup from a tray and took a drink, then returned to bed. At 9:44 p.m., she crawled to fill up a cup at the sink, and again returned to bed. At 10:30 p.m., CG1 noted in the Log that AP was “talking in sleep”; and at 10:38 p.m., “using facilities – disoriented – voice rambling on”; ten minutes later she was still using the facilities and had removed her pants; two minutes later she returned to bed. On video fifteen minutes later, AP is seen returning to the toilet for five minutes, then putting her pants on and going back to bed.

CG2 took over from CG1 at 11:30 p.m. CG2 noted at 11:33 p.m. that AP was “moving about – sounds distressed”. CCTV shows her at the sink, then back to bed, then a few minutes later shuffling on her buttocks towards the toilet, then to the cell door to retrieve water. CG2 noted in the Log at 11:47 p.m. that AP was moaning and talking to herself when he provided her water. AP then shuffled back to bed. In the next Log entry, CG2 noted that AP was complaining of pain again; however, he took no action.

Day Five

Through the night into Tuesday, March 29, AP continued to be restless, and her decline was captured on the cell video CCTV. Between midnight and 4:00 a.m., the footage shows AP unsteady on her feet, swaying, and sometimes crawling instead of walking. She can be seen holding her abdomen on several occasions. She consumed water throughout the night, getting up to take a cup from CG2 three times, and at other times refilling the cup herself at the sink. CCTV shows that at 3:23 a.m., AP used the toilet, then returned to bed, then returned to the toilet three more times in the next seven minutes. Between midnight and 4:00 a.m., the Log describes AP as “resting”, “moving”, “mumbling”, “moaning”, “complaining”, and “talking”. CG2 stated that AP drank “more that day than normal” and complained that she was constipated, although he said he did not note that in the Log because he wasn’t sure how to spell it. CG2 said that he observed AP “struggling” to get to the toilet and get back to bed. The Log does not reflect her unsteadiness, her intermittent inability to walk, the numerous occasions she sought water, or her multiple trips to the toilet. Only one of the three occasions when CG2 provided a cup to AP is recorded in the Log.

Watch Commander WO5 told the IIO that she spoke to CG2 upon her arrival at the detachment at 7:00 a.m., and CG2 advised that AP had been vomiting, that she had not eaten, but that she was drinking water. At 7:06 a.m., WO5 entered AP’s cell and asked her what was wrong. AP advised that her stomach was sore. WO5 asked her if she would like EHS to be called and she said she would, so WO5 called the operator and requested EHS “routine” for stomach pains and flu.

At 7:17 a.m., two paramedics arrived at the detachment and went to the cell, escorted by WO5. Paramedic 1 (‘P1’) went into AP’s cell while P2 talked with CG3. WO5 advised the paramedics that AP

was complaining of stomach pain, had been vomiting and wasn't eating. Speaking later with the IIO, WO5 recalled that when P1 asked AP to sit up, AP told him that she was very cold, that her stomach was hard and sore, and that she had not defecated in a few days. Operations Non-Commissioned Officer ('NCO') WO6 overheard that an ambulance was at the detachment and entered AP's cell, asking P1 and WO5 what was going on. WO6 told the IIO that P1 said AP was constipated and needed a laxative. WO5 recalled that P1 also said that AP was hydrating, that her vomit was clear, and that she would be fine.

By WO5's account, AP asked her what she and the paramedics were talking about, and WO5 explained that the paramedics said that she needed to have a bowel movement and then would feel better. WO5 stated that she checked the medicine cabinet but there were no laxatives; she offered AP a coffee but AP declined. CCTV shows WO5, WO6 and P1 departing AP's cell at 7:20 a.m., three minutes after arrival.

CG3 arrived early that morning to relieve CG2 and start his 7:30 a.m. shift. CG3 observed the paramedics arriving. He told the IIO that as soon as they left, he did a cell check. However, while he may have observed AP on his monitor, CCTV shows he did not make a physical check until 7:57 a.m., when he appeared to speak with AP and then provided her a cup through the door. CG3 described AP as complaining repeatedly that she wanted to go home, and that she didn't want to go to court. He made a subsequent physical check on her at 8:16 a.m., and again at 8:24 a.m. CG3 recorded cell checks in the Log at 7:40, 7:54, 8:08, and 8:23 a.m. There is no note of providing her water, as observed on CCTV at 7:57 a.m.

AP periodically shifted and flipped over on the bed until 8:33 a.m., when she slid along the floor on her bottom to the sink, where she appeared to refill her cup before walking back to bed. CG3 appeared to observe her actions on the monitor. AP was restless, rolling around, pushing her pants down then attempting to pull them up again. CG3 made a brief physical check at 8:43 a.m. and again at 8:51 a.m., and continued to watch the monitor. The 9:22 and 9:36 a.m. Log entries, written by CG3 without leaving his desk, state that all prisoners were "calm", but during this time AP was periodically shifting, rolling over, then drinking water from a cup beside her bed. She then crawled to the sink, pushing her cup along, refilled her cup and walked back to her bed, then resumed pulling her pants up and pushing them down again.

CG3 wrote the 9:50 a.m. Log entry without a physical check (the last physical check was at 8:51 a.m.), noting "all calm" and "all good", and that AP was "talking". On the video recording, however, she appears distressed. At 9:52 a.m., AP stood at the cell door and knocked to try to get someone's attention, then knocked again a minute later before making her way back across the cell, dropping to her hands and knees and rolling onto the bed. CG3 appeared to be observing the monitor but did not react. At 9:54 a.m., AP made her way unsteadily back to the door, where she knocked again, resting her head against the door and leaning against the door frame. CG3 attended AP's cell. According to his statement, during his 10:04 a.m. cell check, AP came up to the door mumbling and he was unable to understand most of what she was saying, but she did ask him for a cup of water. CCTV shows AP falling onto the sink and toilet, then sliding down to the floor on her bottom. CG3 observed her fall, then left to check the other cell, and returned to the Guard Room before she got up.

The video shows that AP made her way back to the bed and lay down, but she appeared restless and was holding her head. She then sat up, rolled off the bed and crawled to the sink, pulling herself up to drink from the sink. Her pants fell around her ankles, and she removed them as she stumbled towards

the bed. She fell beside the bed. She then drank from a nearby cup, then rolled on the floor. Appearing disoriented and in distress, AP struggled to sit up. At 10:00 a.m. she managed to roll herself back onto the bed. Between 10:01 and 10:04 a.m. she was restless, sitting up and lying back down twice, rolling around and shifting. CG3 was at the desk in the Guard Room and appeared to be observing the monitor throughout this time. In his statement, CG3 said that he saw AP fall while attempting to sit on the toilet. He said he believed that he then left to get her a cup of water and when he returned with it, she took the cup, then lay on the bed, her lower body hanging off the mattress.

The 10:04 a.m. Log entry notes that AP removed her pants and was yelling and that she was given a cup of water, although the water was actually provided at 7:58 a.m. At 10:04 a.m., AP can be seen on video shifting her legs back and forth and rocking, apparently in discomfort, but by 10:07 a.m., AP has mostly stilled and is lying with her torso on the bed and her lower body on the floor. CG3 continued to sit at the desk reading and checking the monitor periodically.

At 10:18 a.m., CG3 conducted a brief physical check of cells, pausing in front of AP's cell for three seconds. CCTV shows AP moving slightly. CG3's Log entry at 10:19 a.m. notes that the prisoners are "all breathing". By 10:22 a.m., AP no longer appears to be moving at all. CCTV shows CG3 stopped in front of AP's cell at 10:27 a.m. for almost two minutes -- much longer than any previous cell check. It is unclear from the video whether he tried to rouse AP. He returned to the Guard Office and checked the bulletin board, then dialled the phone, but hung up quickly. He then briefly exited into the hallway (off camera), and then returned to the Guard Room and continued to watch the monitor at his desk. CG3 returned to AP's cell at 10:33 a.m. and kicked the cell door twice.

CG3's statement regarding these last actions is contradictory: he initially said that the first time he stopped in front of AP's cell door, he kicked it because he couldn't see any indication that she was still breathing, then amended that to say he could see her breathing. He said he then left and returned within a few minutes, and kicked the cell door again, then bashed it with his hand, and yelled her name. By CG3's account, when AP did not respond, he went looking for a female officer in the main office. However, CCTV shows that he went back to the Guard Room and again checked the bulletin board, dialled the phone and hung up quickly, and sat at his desk observing the monitor. Then at 10:35 a.m., he returned for the third time to the cell hallway and checked both cells briefly. He then passed through the Guard Room and into another hallway beyond.

At 10:36 a.m., CG3 can be seen returning to the Guard Room with WO7, who put on gloves and went to AP's cell, followed by CG3. WO7 told the IIO that she entered the cell and observed that AP looked pale with bulging eyes. She shook AP by her arm and called her name, but AP was "clearly deceased". WO7 then exited the cell and told CG3 that she believed AP had died and to notify WO6. WO7 told the IIO that CG3 said, "Are you sure?", and at 10:38 a.m., WO7 went back in and tried to rouse AP again but found she was "stiff". Advised by WO7 that AP was dead, WO6 immediately went into the cell and looked at AP, then instructed CG3 to call 911 to "get EHS here right away, to check her". WO6 said he believed that there was no point in starting CPR or providing medical attention because AP had been dead "for a little while".

At the time of her death, AP had been in custody for just over 90 hours. It had been over 51 hours since she last ate. She appeared to have been suffering delusions since the afternoon of March 26. She had been vomiting periodically since March 27. At 10:27 a.m. on March 29, CG3 was unable to rouse her,

but it wasn't until 10:40 a.m. that EHS was called. No medical intervention was ever administered after it was discovered that she had stopped breathing.

Medical Evidence

Autopsy & Toxicology Reports

On March 31, 2016, a Postmortem Examination of AP was conducted. The Postmortem Examination Report was completed on January 9, 2017. It was accompanied by a Toxicology Report dated May 10, 2016. The postmortem report concluded that a definitive cause of death had not been identified, but noted that there had been chronic functional obstruction of the intestines, and that opiate abuse and withdrawal were likely complicating factors:

As a result of uncertainties apparent in the report, the IIO investigation advanced to seek additional input from a medical practitioner with expertise in the clinical management of addiction disorders and drug withdrawal.

Expert Medical Opinion

The Delta Police Department (DPD), as part of an independent investigation (mentioned above), had sought an expert medical opinion from a medical practitioner with expertise in addiction disorders and drug withdrawal.

IIO Investigators followed up with this doctor to gain clarity. Several areas were explored, including the symptomology of influenza, drug withdrawal, constipation, and the Post-Mortem findings. The doctor provided two reports, dated June 16 and 24, 2017. He was unable to say definitively whether the care provided to AP was adequate, or whether she should have been taken to hospital at an earlier stage. This was largely because the Patient Care Report prepared by the attending paramedics was inadequate:

> *The bottom line is that the patient care report has insufficient information for me to make any definitive statement on what was or was not considered, what was or was not discussed, and what parts of the history, physical exam, and patient encounter did or did not occur, as the gaps in documentation do not mean a multitude of issues were not either considered, deliberated upon, or in fact done.*

EHS Evidence

As detailed above, there were two EHS members who attended White Rock RCMP cells to treat AP for stomach pains and flu on March 29, 2016. They are referred to in this document as P1 and P2. The Patient Care Report summarized that AP complained of stomach pain and of being constipated for several days, and added that she was not cooperative during the examination. In P1's Occurrence Report, completed shortly after his examination of AP, he wrote:

> *At the time of my assessment a male and female RCMP officer were present. I discussed with the officers about leaving the patient in cells under their care, they were okay with the decision. It was agreed upon, that the RCMP officers will contact EHS if the patient decided to cooperate and/or wanted medical attention.*

Both P1 and P2 refused to submit to in-person interviews with the IIO, but on September 16, 2016, answered questionnaires in writing. In response to IIO questions about AP's examination and treatment, P1 stated that AP "refused assessment", so he told the officers present that she "needed to go to the hospital, but that the decision was theirs, as she had refused treatment". He said that the officers "discussed it between themselves" and "decided to keep her there and monitor her".

According to WO5 and WO6, by way of contrast, AP's lack of cooperation was not a deciding factor on whether she received care. WO5 stated that she was advised by the paramedic in cells [P1] that AP was constipated and would be fine, not that she should be taken to hospital. WO6 gave a similar account.

IIO's Continuing Investigation

B.C. Policing Standards and RCMP Policy

The B.C. Policing Standards require that appropriate policies be written and followed "to ensure that staff recognize, take appropriate action on, and report all prisoner medical emergencies". Further, the Standards stipulate that "no more than 14 hours should elapse between meals", and that "each prisoner be physically visually checked at least every 20 minutes by department staff", and adds, "For the purpose of this standard, a visual check does not include video surveillance".

RCMP policies begin at the National level. Depending on the need for greater detail, or to address local provincial requirements, Division RCMP policy may also be created. For those occasions where additional policies are needed to address local community requirements, Detachment or Unit policies may also be created. Divisional, Detachment or Unit Supplement Policies must complement the National directive and while they may supplement them, they should not contradict them.

National policy specifies checks on prisoners by the Watch Commander at the beginning and end of each shift, and "periodically" during the shift, initialling the logbook each time.

E-Division policy simply talks about the Watch Commander "checking the cell block" during each shift and signing the log each time.

White Rock Detachment policy makes the Watch Commander responsible for cell block operations and requires a physical check of all prisoners once an hour, with any medical issues noted and observations documented in the log in red ink. Detachment policy also requires staff (including officers and guards) to contact EHS immediately "if there is any indication that a prisoner needs medical attention", and states that "EHS paramedics cannot declare a person medically fit" (that is, a prisoner apparently in need of medical attention must be taken to hospital).

Evidence of Cell Checks Conducted on AP

Officers in the role of Watch Commander at various points during the period of AP's detention were WO3, WO4, WO5, WO8 and WO9. Each of their shifts was approximately twelve hours long.

WO3 was on duty for three shifts during the time AP was in cells. Keyscan data records from cell access doors indicate that he visited the cells ten times in total. The Log records him checking on AP twice, once

on March 26 and once on March 28. There are no Log entries in red ink corresponding to those times, recording any medical issue with AP.

WO4 also worked three shifts during the relevant period. There are eight Keyscan data records for visits to cell during those shifts. There are four Log entries regarding interactions with prisoners, one of them in red ink on the evening of March 26, re AP: “Both answered”.

WO8 was on duty during the night of March 25-26. Keyscan data records that she visited the cells five times during that shift. There are four entries about her interactions with detainees, none of whom was AP, and there are no red ink entries indicating any medical issues with AP.

WO9 was on duty for three shifts during the relevant period. Keyscan data indicates that he visited the cells eight times during those three shifts. There are notations in the Log about six times WO9 had dealings with prisoners, none of whom was AP. There are no Log entries in red ink to indicate any medical issue.

WO5 worked two day shifts, including March 29, the morning of AP’s death. On the 28th, there were just three visits to cells recorded. On the 29th, there were nine. A Log entry in red ink for the 28th at 12:55 p.m. notes, “Pris. Checked. All ok. [AP] states she is feeling like she has the flu. Did not wish EHS. Isn’t eating as she feels sick. Likely from detoxing”. On the morning of the 29th, at 7:06 a.m., another red ink entry states, “[AP] compl. of not feeling well feeling well throwing up. EHS called routine”.

In summary, the evidence indicates that, during AP’s period of detention, officers filling the role of Watch Commander did not attend in cells with either the frequency or regularity mandated by White Rock Detachment policy, and very little of AP’s medical distress was recorded in the Log in red ink, as required. There was no formal, documented briefing at shift change times to alert officers to changes in prisoners’ conditions or other concerns. A combination of such factors appears to have played a role in officers not having a better understanding of the significance of AP’s changing condition.

Responsibility for Operations and Safety of Detainees at the White Rock Detachment

At the time of AP’s death, WO6 was a Sergeant in the role of Operations NCO at White Rock. He had been in that role for eighteen months. His immediate supervisor was WO10, the Detachment Commander. Interviewed by the IIO, WO6 stated that his role was overseeing the daily operations of the policing aspect of the Detachment, which included an administrative role, reviewing of files, fleet management, maintenance, health and safety, adherence to policies, quality assessments, prisoner care, and exhibit handling. He said that because the detachment only had 23 members, his role was a “jack of all trades kind of role”.

On his role regarding the cell block, WO6 stated that he was “involved in all aspects”, including “making sure members are reviewing policy” and that both members and guards were actually following policy.

WO6 stated that, because the Detachment was not large, while sitting in the Watch Commander’s office, it was common to hear prisoners yelling and banging on the cell door. He said he attended the cell block when he heard that EHS had arrived to see AP. He said, “I went in, I had a quick conversation with

everybody, it was -- I felt relieved about what they said, and that, you know, it wasn't anything serious. And I came back to my desk to leave [WO5] to oversee what was going on". Later, after EHS had departed and AP remained in the cell, he asked WO5, "When's the last time, you know, we checked on her? And [WO5] said, 'Yeah, that was her and she'd been doing that all weekend. I hear she'd been pretty noisy'. But we knew [CG3] was in, in the guard room and was dealing with, with the care of the prisoners and I came back to my desk and continued on with my work". At approximately 10:30 a.m., he was informed by WO7 that AP had died.

WO6 felt that AP had been monitored within the RCMP guidelines and policy and referenced CG3 providing a glass of water to AP through the slot in her cell door at 10:04 a.m., and then checking on her at 10:19 a.m. and confirming she was breathing.

Regarding prisoner handling and care at RCMP detachments, WO6 stated:

> *Well, generally, you know, I guess it's above and beyond. We are -- above everything else we, you know, we would abide by the RCMP, you know, mission and values and, you know, treating people with respect and having accountability and responsibility and all those words that, you know, we try to live by.*

He added that there were "specific policies" about prisoner care, including those applicable to the "part-time, on-call" civilian municipal employees acting as jail guards, who he said were responsible for "primary care" of prisoners. Asked to elaborate on those "specific policies", WO6 stated that, while aware of their existence, he was "maybe not as familiar with the National or even Divisional policies as far as just kind of like the general overview of it". He stated that it had been five to ten years since he had reviewed National or Divisional policy on prisoner care, and had read the Detachment policy on prisoner care only when he first arrived at White Rock Detachment. He later added,

> *There is really no mechanism for us to say, like me as a supervisor saying 'Okay, it's time for your, you know, your bi-annual review of cell -- of prisoner care and cell block policy.' There is nothing like that. It would be up to the member, the individual members themselves to ensure that they understand policy and that they're current.*

WO6 described the civilian guards as "kind of like the front line of determining what the prisoners might need after they've been lodged in cells". A guard's responsibility, he said, is "literally that eyes on the prisoners at all times to make sure that nothing out of the ordinary is happening", and to "document everything that they see". Physical cell checks, he said, were to determine that the prisoner is "moving, that they're breathing, and if there's any concerns, they'll wake them up … by, you know, banging on the door or calling out to them to make sure that they, you know, can make eye contact and that everything's okay". The guard, WO6 said, would be "looking for anything out of the ordinary". He confirmed that those checks would involve the guard getting up, walking to the cell door and looking through the cell window. At shift change, he said, guards were expected to pass on information about "anything that's going on within the cell block:

> *The information should be passed on. Again it, it's going to be up to the two guards to have that conversation. […] But I know the documentation there in the logbook is just that one's off shift and the next one's on shift. But just like we hand off information to them, or, or each other depending on the situation, they're expected to do the same thing.*

The Watch Commander, WO6 said, was ultimately responsible for the well-being of prisoners, especially those held for multiple days, and he said that all communications with the Watch Commander would be recorded in the Cell Log. WO6 stated that, when in that role himself, he would "go in, touch base with the guard, you know, have a chat how things are going, and that conversation can be literally seconds, you know, if everything is quiet, nothing's going on. Then go and do a physical check in each of the cells that has a prisoner".

Regarding the timing of such checks, he said that it was "subjective, up to them as to how often they go in and check on things". His expectation, as the Operations NCO, about how often a Watch Commander would conduct cell checks, "would be to regularly make sure, you know, to ensure that things are, are okay and to make regular checks. And that would be an informal, you know, request or an expectation, you know, that they know what's going on in cells while they're in charge".

Investigation of RCMP Organizational Processes

Over an extended period, the IIO forwarded numbered questions to RCMP management regarding policies and procedures related to prisoner handling and care, members' roles and performance, audits and training. The following summarizes the RCMP disclosure provided in response:

- 1A) The National, Divisional and Detachment policies relating to prisoner handling and care in place on March 25, 2016, were provided. These have been discussed in the RCMP POLICY & BC POLICING STANDARDS section.

- 1B) The IIO had requested a list of audits during the two years prior to March 25, 2016. Two Quality Assurance clerks review all files for compliance with policy and "conduct of adequate investigations" at the Detachment. Any issues identified would have been brought to the member, the Watch Commander or the Operations NCO, and/or Detachment Commander. The two main processes for auditing Detachment operations are Unit Level Quality Assurance reviews ('ULQAs') and Management Reviews ('MRs'). Typically, ULQAs identify high risk activities and the audit is conducted of the Detachment's performance of those activities, whereas MRs are more comprehensive, and usually conducted by request. Directed Reviews ('DRs') are targeted at a specific urgent matter requiring remediation.

- 1C) Regarding the frequency of audits: ULQAs are conducted annually. MRs are conducted as a result of a risk assessment process and by request. There has been no DR at the Detachment.

- 1D) Regarding the outcome of the audits: there is no record of Quality Assurance reviewers identifying any issues relating to prisoner handing and care at the Detachment. The ULQAs in the two years prior to March 25, 2016, did not address prisoner handling or cell block operations, and there were no MRs conducted at the Detachment during that period.

- 2A) The IIO had requested any changes made to National, Divisional and Detachment policies relating to prisoner handling and care since March 25, 2016. There were no changes made to Divisional or Detachment policies during that period. Table Q2A below sets out the relevant changes to National policies since that date.

- Q2A: Relevant changes to National policies relating to prisoner handling and care since March 25, 2016:

Policy Section	Policy Amendments since 2016-03-25	Change
OM 19.2 Assessing Responsiveness	Consider seeking a medical assessment if an individual is suspected of having a drug or alcohol addiction and if they have been detained for longer than eight hours. Refer to OM ch.18.1., Arrest and Detention, sec.7, Arrest/ Incarceration of Intoxicated Persons	Revised from 12 hours to 8 hours, and the policy section reference was added.
	2.3 Granting Access to Medical Assistance 2. 3. 2. 1. 2. any behaviours that could endanger the prisoner or others; NOTE: If a member believes that an individual's (prisoner's) mental health is a contributing factor in the need for medical assistance, refer to OM ch. 19.7., Mentally Ill Persons/Prisoners. 2. 3. 4. 1. Clearly articulate in your notebook, the rationale for a decision not to transport the prisoner to a medical facility for treatment. 2. 3. 2. 1. 2. any behaviours that could endanger the prisoner or others; 2. 3. 2. 1. 5. the nature and degree of any force used to arrest the prisoner.	Section added
	3. Guard 3. 1. The guard on duty is responsible for determining the responsiveness of each prisoner in cells, and must be familiar with the requirement to assess prisoner responsiveness and conduct assessments. Refer to App. 19-2-1. 3. 2. Do not attempt to determine the degree of responsiveness of a prisoner who appears less than fully conscious. If the prisoner appears to be less than fully conscious, seek immediate medical assistance and ask a member to assist. 3. 3. Never assume a prisoner is "sleeping it off". Assess responsiveness as per App. 19-2-1. 3. 4. For further information regarding guard responsibilities pertaining to guarding prisoners and assessing responsiveness, refer to OM ch. 19.3., sec. 4., Guard. **4. Supervisor/Shift Supervisor** 4. 1. Ensure that a copy of the Rousability Chart, App. 19-2-1, is posted for the attention of all members and guards in the cell area.	Further amendments to 3.1, 3.3, and 4.3

	4. 2. Review and sign Form C-13-1 to ensure that prisoners are being assessed appropriately. 4. 3. Where practicable, conduct a visual check of prisoners and document your observations on Form C-13-1, and in the prisoner log record book. **5. Unit Commander** 5. 1. Ensure that all personnel under your command are familiar with policy requirements in regard to assessing responsiveness and medical assistance as well as all RCMP prisoner policies.	
OM 19.3 Guarding Prisoners	Prisoner Report, Form C-13 was revised to include space to document time/date of last consumption of alcohol or drugs to "Possible cause of Impairment" box; pre-existing medical conditions, and allergies.	Sections added

- 2B-C) The IIO asked if there were audits in place to ensure compliance with new policies, and about the related procedures. The RCMP replied that the audits are as described in 1B and 1C. Any changes to policy are communicated via broadcast to the entire RCMP. Those broadcasts are briefed to members via Detachment-wide emails, Watch briefings and Unit meetings. The changes are also posted in cells. A record of the changes is retained at each level. Compliance is ensured through monitoring of prisoner handling and cell block operations by Supervisors and NCOs, and reviews by Quality Assurance clerks.

- 3) The IIO provided a list of fifteen Coroner's Inquests of cell deaths, dated 2006 to 2015, and requested any changes made to National, Divisional and Detachment policies covering prisoner handling and care arising from those findings in the twelve months prior to March 25, 2016.

Cellblock related recommendations accounted for 30% of the total recommendations. The recommendations show "a significant downward trend over time", likely due to RCMP and municipal policy changes implemented over the years, along with substantial changes to the C-13 Prisoner Report.

The RCMP noted that any amendments made as a result of those Inquests would not likely be within the twelve-month time frame and provided an inventory of *all* Coroner's Inquest recommendations from 2006 to 2015 for which a change had been made at the time of writing. The changes relevant to issues in this file are documented in Table Q3 below:

- Q3: Changes to policies relating to prisoner handling and care arising from Coroner's Inquests (2006 to 2015)

Date	Inquest	Policy Amendments	Change
2014-01-23	Surinder MALHI	Shift report should document behavioural issues; manager to be advised. C-13 changes to health must be changed by RCMP officer and show author, date, and time. Notes pertaining to prisoners should be in a log book where all employees can see to ensure better communication. A screening tool for alcohol withdrawal would help in early detection.	Surrey cellblock SOPs amended
2014-03-07	Jeremy RICHARDSON	Amend policy regarding a further assessment after a 3rd check with no movement. Develop questions for booking in to determine medical conditions or level of intoxication. Reminder of existing policy on EHS assessment for intoxication, and First Aid/ CPR requirements prior to EHS arrival.	Local policy amended to reflect NHQ Policy
2015-02-05	Steven SCOTT	3.1.4. Consider a medical assessment of known or suspected substance abusers. Look for symptoms of withdrawal. 4.2.3. Guards must receive an initial orientation on all levels of RCMP prisoner policy pertaining to their duties, including cell-block security and medical assistance. This includes reviewing specific policy every six months.	Previously policy did not reference withdrawal.
2015-10-21	Alyssa GEORGE	See Table Q2A above	

- 4A) The IIO asked how the RCMP in BC consider, assess, and action suggestions or recommendations from any individual or organization in relation to prisoner handing and care at the Detachment. The RCMP responded that this encompasses so many possible situations that it is difficult to respond and added that if an external factor prompted the review and/or change of policy at any level, "those responsible would undertake to do so."

- 4B) What mechanism is in place to make any necessary changes to RCMP policy? The Operational Policy and Compliance (OP&C) Section replied that at the National level, a

consultation framework is in place to facilitate policy changes. Reports of in custody deaths are assessed for compliance with policy. Changes to policy may also be triggered by other sources including open-source information, media reports, non-RCMP police reviews and case law. Changes are developed in consultation with all Divisions, so that changes to National policy may trigger Divisions to review their corresponding policies during the consultation process.

- 4C) Who oversees the above mechanisms and processes? The OP&C Section manages the change process at the National level and initiates changes following the consultation framework. The step-by-step process for changing policy at the Divisional level is described in a process map which was provided.

- 4D) What mechanisms are in place to make changes to policies in relation to prisoner handling and care at the Detachment? In addition to the processes discussed in 4B and 4C, Detachment command staff have the authority to make changes "based on local situations, conditions and experience."

- 5A) The IIO asked for a description of the roles and responsibilities at the Detachment for the following positions:

    - Assistant Commissioner, Chief Superintendent, Superintendent: responsible for ensuring the broadcast and implementation of any amendments to RCMP policies;

    - Inspector: conducts the performance evaluations of the Detachment Commander;

    - Detachment Commander, Ops NCO, Watch Commander, Custodial Guard: these roles are described in National, Divisional, and local policies provided in the answer to Q1A;

    - Operations Manual (OM) 19.3 Guarding Prisoners and Personal Effects describes the responsibilities of the Commander, Supervisor/ Shift Supervisor, and Guard duties, responsibilities, and training in this context;

    - OM 19.5 In-Custody Death describes the role of NCO during an in-custody death;

    - E Div OM 18.1 Arrest and Detention describes the role of NCO/ Commander in the arrest process;

    - E Div OM 19.2 Assessing Responsiveness – Medical Assistance describes the role of Commander and Guard in this context;

    - E Div OM 19.3 Guarding Prisoners – Personal Effects describes the role of Detachment Commander in this context, including the responsibility for checking the Prisoner Report (C-13) and Prisoner Log for accuracy and completion;

    - Prisoner Handling – Cell Block_2019 is a White Rock Detachment Unit Supplement which discusses the role of the Operations NCO, the Detachment Commander, and Guard in this context; and

- Administration Manager: known as the Support Services Manager – this is a municipal employee so RCMP have advised that their role and responsibilities would have to be obtained through the City of White Rock, however, the role is described in Prisoner Handling – Cell Block_2019 above.

- 5B) What mechanisms were in place to ensure the individuals listed above were fulfilling their duties? The RCMP supplied the policy regarding annual performance evaluations, mid-year assessments, performance logs, and other performance management tools. The performance management process for the Custodial Guards and the Support Services Manager would have to be obtained through the City of White Rock.

- 5C) How is performance monitored, and shortcomings identified, addressed, and rectified? Performance appraisals are completed both halfway through the year and annually. Any performance issues may be addressed during those reviews. Additionally, Performance Logs are used to document, inform, and correct any performance issues or document notably good performance throughout the year.

- 6) The IIO asked about the process of risk management and audits at the Detachment in relation to prisoner handling and care prior to March 25, 2016. The policy relating to Unit Level Quality Assurance Reviews and Management Reviews is discussed in 1B and 1C.

- 7A) The IIO requested any Management Reviews conducted at the Detachment in the 24 months prior to March 25, 2016. There were none during that period.

- 7B) The Management Review for the Detachment, dated February 20, 2018, was requested. The White Rock Detachment Management Review Report (Report) covering the period between September 16, 2016, and September 15, 2017, notes deficiencies in the following pertinent areas:

    - A clearer division of roles and responsibilities between supervisors;
    - Ensuring reporting lines are identified;
    - Compliance with guard training requirements;
    - Physical checks of cells by guards during a shift change;
    - Checking responsiveness of intoxicated prisoners;
    - Cell checks by shift supervisors and associated documentation in the Log; and
    - Adequate completion of C-13 Prisoner Forms.

- These deficiencies resulted in Recommendations, and the requirement that the Detachment Commander submit an Action Plan addressing the Recommendations to the OIC “E” Division Review Services within 30 days of receipt of the Report, and subsequently forward quarterly updates on March 31, June 30, September 30, and December 31, 2018.

- 7C) The IIO requested any subsequent Management Reviews conducted at the Detachment since the one dated February 20, 2018. At the time of disclosure, there had not been any since.

- 8) The IIO asked if there was a Training Manual for officers dealing with prisoner handling and care at the Detachment and requested a copy in effect during various time periods. The RCMP replied that training in the handling of prisoners is provided at Depot during recruit basic training. Members arriving at the Detachment are expected to familiarize themselves with the White Rock Unit Supplements to National and Divisional policy, as well as local policy and practices. There is no manual for White Rock or E Division: members are expected to observe the National standard.

- In 2019, the Acting NCO developed a workshop for NCOs and guards to refresh their understanding of the current policy on prisoner handling and care. The workshop had been held twice at the time of writing; the associated materials have been provided in the disclosure.

- National, Divisional and Detachment policy is provided in Q1.

- 9) The IIO asked a further question about training, which was answered in Q8.

- 10A) The IIO asked what role the White Rock RCMP played in the supervision, training and management of the custodial guards who worked at the Detachment prior to March 25, 2016. The Acting NCO at the Detachment replied that all guards received Commissionaire training for handing prisoners, which is conducted by a trainer from the Commissionaires, not a member of the RCMP. The Acting NCO advised that he had sat in on the last few training sessions to offer a member perspective and assist in explaining RCMP policy. The guards receive a training package along with a copy of Unit Supplements relating to cells and prisoner handling. The Acting NCO has instituted a training session with Watch Commanders and guards that takes place twice a year.

- The OP&C advised that the guard manual is currently being updated, but at the time of writing, the manual referred to in Operations Manual (OM) 19.3, last updated in 2004, remains the standard:

    - 4.2.2. Guards will receive training equivalent to that which is outline in the RCMP Guards Training Course Standard (CTS CL000007) as a condition of employment;

    - 4.2.2.1. This includes guards that are employees of outside agencies contracted to guard RCMP prisoners;

    - As long as the training received by Commissionaires is equivalent, it is deemed acceptable; and

    - The training provided for the guards at the Detachment is provided by the City of White Rock and based on the training given by the Corps of Commissionaires. Included in the disclosure is the Course Training Standard provided by the RCMP.

- 10B) The IIO asked if that role (referring to the role of White Rock RCMP in the supervision, training, and management of the guards) has changed. The RCMP replied that it has not changed.

- 11) The IIO asked if there was a training manual for custodial guards conducting prisoner handling and care at the Detachment. The RCMP replied that the training for guards at the Detachment was provided by the City of White Rock, based on the training standards provided by the Corps of Commissionaires, and requests for that training material should be directed to the City of White Rock.

- 12) The IIO asked if, prior to and since March 25, 2016, there have been any training courses for officers in BC relating to the protocols for prisoner handing and care at the Detachment, and if so to provide the course information. The RCMP answered that there is an expectation that members will adhere to the National policy for prisoner handling and care at all Detachments. Member handling of prisoners is overseen by the Watch Commander to ensure compliance. Files are reviewed by Quality Assurance to ensure that policies were followed; any necessary corrections are communicated to the member and supervisor. Changes to policy are communicated through broadcasts, reinforced at Watch briefings, and posted in cells. As covered in Q8A, the training for members occurs at Depot.

- 13A) The IIO asked how the Commanding Officer of E Division ensures that all training and any refresher training related to prisoner handling and care for both officers and guards at the Detachment is up to date. The answer is that the Commanding Officer ('CO') is not involved in the supervision of recruit training or the distribution of policy changes. The CO expects that any member who has completed training at Depot has also successfully completed the module on prisoner handling and care; without doing so the member would not pass. The CO also expects that the civilian guards have completed the required training provided by the City of White Rock. Finally, the CO expects that the well-established processes for disseminating new policy or changes to policy will be followed.

- 13B) How does the CO ensure that proper audits are conducted? The CO is not involved in the supervision of ULQAs or MRs. Any failure to comply with the audit processes would be addressed at the appropriate level. If the situation warranted, non-compliance could be reported to the CO. This has not been an issue at the Detachment.

- 13C) How are the results of audits communicated to the CO? ULQAs are not normally communicated to the CO, but are managed through the reporting lines of the RCMP corporate management structure. MRs are provided to the CO by Review Services, on completion of the final report. If the audit revealed issues which exposed the public or the RCMP to risk, these issues could be reported to the CO, depending on the severity. The CO expects that the layers of command between the CO and the Detachments will competently manage these processes.

- 13D) If there are any deficiencies, how are they addressed? Appropriate courses of action are developed at the appropriate level – from Detachment level up to Headquarters. If an issue was serious enough to warrant the attention of the CO, the CO would review the action being taken to rectify the situation to ensure it was appropriate.

- 13E) What is the frequency of audits? Answered in Q1B and 1C.

- 14) The IIO asked about the training new officers at the Detachment have received on prisoner handling and care, and requested copies of the training strategy, course training standards, and the course outline. As previously stated, the formal training occurs at National level, at Depot. New members are directed to the Unit Supplements for White Rock Detachment. These are local policies, supplemental to National and Divisional policy. There is no standard training or tracking of the review of Unit Supplements. See also Q8A, 12A and 12B regarding training.

- 15A) The IIO asked what training on prisoner handling and care has been provided to Detachment Commanders and Operational NCOs in BC? Detachment Commanders and NCOs receive training at Depot and would be expected to become familiar with any Unit Supplements upon arrival. Policy regarding ULQAs and MRs also provide education on prisoner handling.

- 15B) From March 25, 2014, to March 25, 2016? Answered above in Q15A.

- 15C) Since March 25, 2016? In developing the workshop referenced in Q8, the Acting NCO has enhanced his own familiarity and proficiency with the policies.

- 16) The IIO asked for the training on prisoner handling and care provided to the individuals at the Detachment at the time of AP's incarceration. The answers regarding members' training are provided in Q8A, 12A, 12B and 14. The training records of the three civilian guards would have to be obtained through the City of White Rock.

Further RCMP Evidence

On August 15, 2018, an IIO investigator met with the White Rock Detachment Support Services Manager, Civilian Witness 3 ('CW3'), and WO11, who replaced WO6 as Operations Support NCO, to review any changes in policy and training relating to guards and operations. CW3 stated that she had instituted a regular mandated training schedule and advised that both guards and Watch Commanders receive "update and review" training every six months.

The training covers the review of all policies on the care and handling of prisoners and includes instruction on the proper completion of C-13 Prisoner Booking forms. CW3 advised that both guards and Watch Commanders are trained to check that all prisoner information is recorded on the C-13, and that this information is passed on at shift changes and as needed during the prisoners' incarceration. Guards and officers are also instructed on the importance of thorough documentation of prisoner behaviour and health in the Prisoner Log Book; Watch Commanders are reminded of the importance of noting their prisoner checks in red pen in the Log.

Guards are now instructed that if they have concerns about the well-being of a prisoner and no officer is available to check on the prisoner, the guard should contact EHS immediately for medical assistance rather than wait for an officer. Furthermore, guards have been advised that EHS paramedics are not "capable of diagnosing illnesses or overdoses", so if a guard is concerned about a prisoner's well-being, the guard should insist that the prisoner receive medical attention by a doctor or be taken to hospital, regardless of the paramedic's evaluation. CW3 stated that the training sessions encourage

communication between the guards and the officers, and their working relationship has improved as a result. Guards are also encouraged to provide feedback on daily operations involving prisoner care and handling.

According to CW3, random performance checks of the guards now take place three to four times between training sessions to ensure they are meeting policy requirements; the Prisoner Log Book and corresponding video is also checked for compliance.

CW3 also stated that prisoners are not to be detained in White Rock Detachment for more than four days; instead, they are to be transferred to Surrey Detachment who will take prisoners providing they have the space. Lastly, CW3 advised that extensive changes have been made to food available for prisoners and there is now a selection of 12-14 full frozen meals available.

These significant positive changes likely arose from the Action Plan required to correct the deficiencies noted in the White Rock Detachment Management Review Report, mentioned at page 16 above in the RCMP response to IIO question 7B.

LEGAL ISSUES AND CONCLUSION

General

The Independent Investigations Office of British Columbia has been given the task of investigating any incident that occurs in the province in which an Affected Person has died or suffered serious physical harm and there appears to be a connection to the actions (or sometimes inaction) of police. The aim is to provide assurance to the public that when the investigation is complete, they can trust the IIO's conclusions, because the investigation was conducted by an independent, unbiased, civilian-led agency.

In the majority of cases, those conclusions are presented in a public report such as this one, which completes the IIO's mandate by explaining to the public what happened in the incident and how the Affected Person came to suffer harm. Such reports are generally intended to enhance public confidence in the police and in the justice system as a whole through a transparent and impartial evaluation of the incident and the police role in it.

In a smaller number of cases, the evidence gathered may give the Chief Civilian Director ('CCD') reasonable grounds to believe that an officer has committed an offence in connection with the incident. In such a case, the *Police Act* gives the CCD authority to refer the file to Crown counsel for consideration of charges.

Further, while the applicable section of the *Police Act* refers to 'an officer', there is no doubt that a referral for prosecution can be made with respect to multiple officers or to groups of officers jointly. A simple example would be a situation where several officers jointly use what appears to be unjustified force against an Affected Person, and such referrals have been made, on occasion, in the past.

In this case, as described above, IIO investigators initially designated a number of individual RCMP members as Subject Officers and gathered evidence about the performance of their duties as individuals.

As that evidence mounted, though, it appeared that, if there was criminal culpability for AP's death—beyond whatever failures lay at the feet of the civilian guard—consideration had to be given to possible 'organizational criminal liability' on the part of the RCMP itself.

Specifically, the potential liability flowing from a death in police custody would be in the nature of criminal negligence. The relevant evidence would go to whether officers, individually or collectively, met the applicable standard of care. In order to constitute the offence of criminal negligence, the actions of the accused (whether an individual, a group of individuals or an organization as a whole) would have to fail to meet the required standard of care in a 'marked and substantial' way, such that it showed a 'wanton and reckless' disregard for human life. This is a significant test, as Canadian criminal law does not criminalize 'ordinary' negligent errors, just very significant ones that therefore justify a criminal sanction.

'Organizational criminal liability' is a concept introduced into the Canadian *Criminal Code* in 2003 by an amendment adding section 22.1, which reads as follows:

> *In respect of an offence that requires the prosecution to prove negligence, an organization is a party to the offence if*
>
> *(a) acting within the scope of their authority*
>
> *(i) one of its representatives is a party to the offence, or*
>
> *(ii) two or more of its representatives engage in conduct, whether by act or omission, such that, if it had been the conduct of only one representative, that representative would have been a party to the offence; and*
>
> *(b) the senior officer who is responsible for the aspect of the organization's activities that is relevant to the offence departs — or the senior officers, collectively, depart — markedly from the standard of care that, in the circumstances, could reasonably be expected to prevent a representative of the organization from being a party to the offence.*

When Bill C-45 was tabled, proposing adding section 22.1 to the *Criminal Code*, the Canadian Department of Justice published a plain language guide to assist the public with its interpretation The guide reads in part as follows:

> *In general, for an organization to be found guilty of committing a crime of negligence, the Crown will have to show that employees of the organization committed the act and that a senior officer should have taken reasonable steps to prevent them from doing so […]*
>
> *With respect to the physical element of the crime, Bill C-45 (proposed s. 22.1 of the Criminal Code) provides that an organization is responsible for the negligent acts or omissions of its representative. The Bill provides that the conduct of two or more representatives can be combined to constitute the offence. It is not therefore necessary that a single representative commit the entire act.*
>
> *For example, in a factory, an employee who turned off three separate safety systems would probably be prosecuted for causing death by criminal negligence if employees were killed as a result of an accident that the safety systems would have prevented. The employee acted negligently. On the other hand, if three employees each turned off one of the safety systems each thinking that it was not a problem because the other two systems would still be in place,*

they would probably not be subject to criminal prosecution because each one alone might not have shown reckless disregard for the lives of other employees. However, the fact that the individual employees might escape prosecution should not mean that their employer necessarily would not be prosecuted. After all, the organization, through its three employees, turned off the three systems.

As for the intent necessary to find the organization guilty, the proposed amendments under Bill C-45 would require that the senior officer responsible, or senior officers collectively, must have departed markedly from the standard of care that could be expected. The organization might be convicted if, for example, the director of safety systems failed to give the one negligent employee basic training necessary to perform the job.

Similarly, in the example of three employees engaging in the negligent conduct, the court would have to decide whether the organization should have had a system to prevent them acting independently in a dangerous way and whether the lack of such a system was a marked departure from the standard of care expected in the circumstances. The court would consider, under this example, the practices put in place by the person in charge of safety at the factory and the practices of other similar organizations.

At the same time that section 22.1 was enacted, special sentencing provisions were also added to the *Criminal Code*. Upon conviction for an indictable offence, very heavy fines can be imposed, but more importantly in a non-commercial case, an organization can be placed on probation. Probation conditions can be remedial, aimed at reducing the likelihood that the organization will re-offend and the likelihood of future harms. Conditions available to the courts include those that would direct the organization:

- to implement policies and procedures aimed at reducing the incidence of further negligent acts;
- to communicate those policies and procedures to employees;
- to identify a senior officer responsible for overseeing their implementation; and
- to report at specified intervals on progress.

It could quite reasonably be concluded in this case that AP's death was the cumulative result of poor training, lack of adherence to established policies, the misinterpretation of her symptoms, and the established protocols that invited mistakes by those charged with her care, in particular the police officers and civilian guards. The situation was undoubtedly further complicated by the stigma associated with drug addiction and the underappreciation of the risks associated with detoxification.

AP's Presentation and Failure to Treat

The investigation revealed that those interacting with AP while she was in custody had varying understandings of what was ailing her at the time:

- Regarding her ***drug use***, AP told WO1 at the time of her arrest she used drugs the day before her arrest (March 24, 2016).
- Despite this, the *'**drugs**'* notation on AP's Prisoner Form (C-13) was not checked off.

- AP was asked by WO5 if she was detoxing from ***drug use***, but AP stated that she hadn't taken drugs for a long time.

- AP told WO2 and WO5 that she was suffering from the ***flu***.

- The Guards and WO5 nonetheless believed that AP was suffering from ***drug withdrawal.***

- AP told EHS she was suffering from ***constipation.***

- EHS believed she was suffering from ***drug withdrawal*** and ***constipation.***

- Subsequently, in a statement given to the IIO on April 15, 2016, CW1 said that he and AP ingested ***heroin*** just prior to her arrest.

Those arrested and taken into custody are not required to provide a full medical history to the jail guards, and often do not; the information they choose to provide is voluntary. While the guards will often ask if any prescribed medication will be required while in custody, there is little likelihood the prisoner would also provide full disclosure of any recent illicit drug use. Notwithstanding these voids of information that could impact a prisoner's health, the prisoner is at a significant disadvantage lodged in a cell without ready access to outside medical assistance.

While guards are trained to make observations and to report a prisoner's medical distress, less recognizable symptoms of illness would undoubtedly be missed, or unappreciated for any underlying severity. There is also the potential for unconscious biases based on previous interactions impacting their conclusions and resulting in observations of some behaviours being discounted. However, a trained medical professional would most likely be able to interpret the symptoms more objectively and recognize any risk they present.

There was sufficient information that AP was suffering from some form of ailment, whether it be the flu, constipation, recent drug use, or detoxing. There was also, however, an unjustified presumption, based on the last Log entry, that despite some form of ailment, the prisoner was well and healthy when her condition was actually worsening. As AP's condition was becoming increasingly dangerous, the severity of her medical distress was not appreciated.

Had AP undergone regular physical examinations by a trained medical professional, recording all the necessary information for the next examiner to include in their own subsequent examination, it is highly probable that her condition would have been recognized and treated. Relying on untrained personnel to make that level of assessment, when an incorrect diagnosis is perilous, was dangerously unreliable.

Large police agencies and RCMP Detachments have invested in the presence of trained medical professionals to be physically staffed within the cell blocks. While some smaller police agencies and RCMP Detachments have opted to forgo that financial burden because they detain fewer prisoners, they are nonetheless not absolved from the responsibility of adequate prisoner care.

White Rock Policy Failures

While the RCMP Operational and Administrative National, Divisional and Detachment policies are voluminous and constantly being revised, such that possessing an exact understanding of each area of

responsibility is difficult or perhaps impossible, there exist some areas of greater risk that demand closer scrutiny. Prisoner care is one such area. At his interview, WO6 estimated that he had last reviewed Prisoner Care policy five to ten years prior, and Detachment policy 18 months prior, when he was transferred to the Detachment. This is clearly unsatisfactory.

WO6 understood that the guards were to physically check the prisoners every 15 minutes, while policy required every 20 minutes. Regardless of that minor discrepancy, it does not appear the guards were adhering to either requirement with any consistency. Had a Unit Level Quality Assessment ('ULQA') explored this area, the CCTV footage and Log would have readily discovered the shortcoming.

WO6 also understood that the Watch Commanders were required to make only regular cell checks during their shifts, where National Policy required the 'Shift Supervisor' to conduct checks of the cell block at the beginning of each shift, and periodically during and at the end of the shift. Despite the National requirement, White Rock Detachment policy required greater attention to this area and defined their responsibility to "conduct random visual checks of the prisoners/cell block at least once every hour and will document observations in the Prisoner Log Book in red ink". [emphasis added]

For supervisors to provide the most accurate direction to subordinates and supervise them in carrying out their responsibilities, they must first be well informed of those responsibilities. In fact, WO6 provided such a scenario in his statement, where he described that should informal training be needed where there was a disagreement as to what policy required, the procedure would be to

> *[…] get everybody's information and input on it, and then you have to go away and review policy and make a decision and then get back and say, 'Okay. Hey, this is what it says, this is how we're going to do it here. And from this point forward this is the law. This is the rule. This is how we are going to do it.'*

As demonstrated by the Keyscan data, the Log and CCTV footage, the Watch Commanders attended the cell block during their respective shifts for a variety of purposes. However, their attendance does not appear to have occurred with any regularity at the beginning nor end of shifts, and most certainly not at the rate of once per hour as required by White Rock RCMP Policy. Over the course of four days and four hours, only three Watch Commander inspections were recorded in the Logbook in red ink.

As the Watch Commanders transferred their various duties and responsibilities onto the next oncoming Watch Commander, there was no formal, documented briefing as to what had occurred in the past twelve hours that could impact or influence the next twelve hours. Specific to the prisoner activity and their well-being, the only documentation is the brief, often one-line summaries recorded by the guards in the Log as to the prisoners' activities or complaints.

Most significantly, White Rock Detachment staff, officers and civilian guards alike, including CG3, the guard on duty during AP's last few hours alive, seem to have exhibited what can be considered a negligent attitude towards AP's welfare while she was in their custody. After all, the behaviours and actions of AP, especially the symptoms of delusion, vomiting, unsteadiness, failure to eat, and incontinence ought to have been enough to lead to a conclusion that AP was in need of medical attention earlier than the morning of March 29. While the Delta Police investigation has determined that negligence did not rise to the high standard to give grounds for a criminal charge, there certainly were many signs that AP was very unwell and needed medical attention. The actions of CG3 in picking up the phone but

failing to place a call, standing outside AP's cell for a longer than average period of time, and appearing to watch AP closely on the video feed, are consistent with CG3 being concerned about AP's medical condition. That concern alone should have been enough to ensure medical attention was sought.

Of course, there is no doubt that the advice received from the EHS personnel earlier in the morning played a role in CG3's inaction. While the evidence is contradictory as to what P1 told the police, on balance I find that P1 told police AP was okay and just constipated. P1's suggestion that he stated that AP should go to hospital but it was up to the police seems unlikely for two reasons: (1) it was within P1's prerogative to insist that AP was going to hospital, which he did not do; and (2) if police were given that advice it would seem unlikely they would not simply send AP to hospital with the paramedics who were already there.

This then would seem to have created a situation where police and guards were left with a conclusion, now known to be incorrect, that AP was fine. This helps to explain police and CG3's subsequent actions. Simply put, even though AP was acting unwell, they had the contrary advice of P1.

One could point to many facts that should have led different police officers to act much sooner. Again, though, finally on the morning of March 29 they did act, and called in EHS. This act, although perhaps late, was in furtherance of their duty to seek medical assistance.

After that visit, as noted, on balance I accept that when P1 concluded his assessment, his advice to police was that AP would be fine and that she was suffering from constipation. With that, it is understandable why police were prepared to leave AP again in the care of the guards after that visit.

Therefore, in the end, it cannot be said that any inaction by officers showed a wanton and reckless disregard for human life. Mistakes were made, but the behaviour was based on misunderstanding AP's condition, being too quick to attribute it to drug withdrawal symptoms, and assuming those were not life-threatening. Of course, withdrawal can indeed be life threatening especially if coupled with other physical conditions. But as a result, this misunderstanding, while mistaken, does not show a wanton and reckless disregard for AP's life. This is supported by the fact that EHS was called out of a concern for AP's welfare.

As a result, it is not possible to say that the actions of any police officer rose to the level of criminality.

Application of the Law of Organizational Criminal Liability in this Case

From a broader perspective, the overall negligence demonstrated may well have been related to a failure of police to adhere to written policies or to follow training, as well as failures in follow-up audits to verify adherence to training and policies. The evidence gathered in this case shows that officers who were notionally responsible for ensuring that subordinates, including civilian guards, were regularly reviewing and strictly following policy, were not themselves regularly reviewing policy or reading updates. There was no functioning mechanism for ensuring that this was being done, with members being left to their own devices to stay current and to understand what was expected of them. Responsibility for those failures, effectively, flowed upwards through the RCMP 'system', through progressively senior ranks, implicating the organization as a whole.

Applying and paraphrasing the framework of *Criminal Code* section 22.1, where the potential criminal offence is one that requires the prosecution to prove negligence (in this case, criminal negligence causing death), the RCMP would be guilty as a party to that offence if,

- acting within the scope of their authority (which they were),
- one or more of its officers or civilian guards engaged in negligent conduct, and
- the senior officer or officers responsible for the relevant RCMP activities (custody in cells and the welfare of detainees) departed markedly from the standard of care that could reasonably be expected to prevent an officer or guard from committing the negligent act(s).

Criminal Negligence Causing Death

An organization commits criminal negligence if, in doing something, or in omitting to do something that it is its lawful duty to do, it shows 'wanton or reckless disregard' for the life or safety of a person. It must be proved that there was a 'marked and substantial' departure from the objectively reasonable standard of care expected in the circumstances. Of particular relevance to an organization such as the RCMP, the objective standard is 'informed' by the activity in question, with less tolerance for performance falling short of expectations where the organization is characterized by experience in the activity and purported professionalism.

The failure does not have to be wilful or deliberate. Courts have found, though, that there must be some minimal blameworthy state of mind, which has been described as "advertence" or "wilful blindness" to the risk.

To put it in plain language, it must be shown that the accused organization knew the conduct was dangerous, and did not care.

The first part of that test, as it must be applied here, is whether the RCMP had been put on notice that there was danger to detainees in cells if policies and procedures were not followed by staff. That is, did it know?

E-Division of the RCMP is responsible for policing a large proportion of British Columbia. Between 2006 and 2013, 15 Coroner's Inquests were held with respect to the deaths of people in RCMP custody in B.C., and juries made recommendations to RCMP management. Some examples are:

- A male died in cells from alcohol intoxication. The jury heard evidence that RCMP policy regarding prisoner assessment and obtaining medical assistance was not followed and recommended that steps be taken to ensure full compliance with policies.
- A male died in cells from respiratory arrest. The jury was told that guards did not receive training for critical incidents in cells and recommended that both officers and guards receive cell crisis training.
- A male died in cells from a head injury. The jury heard that RCMP policy around monitoring of prisoners was not followed, that training of guards was minimal and infrequent, that written policy was not well known, understood or adhered to, and that there were no consequences for such

failures by staff. The list of jury recommendations included implementing fully-documented semi-annual retraining.

- A male died in cells from a brain bleed. Officers did not pass information between shifts. Officers finding the male unresponsive did not attempt first aid. Jury recommended a system be put in place for information to be passed between shifts, and that officers be required to initiate first aid before ambulance arrival.

- A male died in cells from methadone toxicity. Evidence did not establish that guards followed procedure by visually checking prisoners on a regular basis. Jury recommended a policy for 'rousability' checks on prisoners every two hours.

- A female died in cells from a cardiac arrest. Jury found the multi-level RCMP policy system was confusing and challenging for officers and employees. Cell policies were not being followed and guards were not properly trained. Comprehensive recommendations for improvements were made.

- A male died in cells from liver failure. Jury found that officers and guards were not aware of the complications of alcohol withdrawal, and officers did not know which level of RCMP policy they were supposed to follow. A recommendation for closer monitoring of prisoners was made.

So, the first part of the test is met: the RCMP knew there were issues that needed to be addressed.

The second part of the test (did it care?) involves a far more difficult assessment. On the one hand, the evidence indicates that the organization has attempted, at least, to respond appropriately to the need to improve. As shown above, the IIO has been presented with lists of changes to policies that—at least on paper—should have led to incremental improvements in care for vulnerable detainees. On the other hand, the plain facts of this case show that many of those written policy improvements had not crystallized into a sufficient improvement for help to be sought for AP earlier than the morning of March 29. What appears to be missing is the presence in the organization of individuals tasked specifically with the job of following up on policy, particularly with members and civilian employees at that 'front line' level.

Any officer, in particular a more senior officer who is a Watch Commander, should always prioritize prisoner safety given the many inherent risks involved with housing persons who may suffer from a multitude of physical, mental, and substance abuse ailments. Knowing and following all policies related to that care should be a high priority. While it may be commendable that there are written policies in place setting out the precise duties of every member of staff at a Detachment, it is critical that someone is ensuring every member fully understands and follows those duties.

The question remains: can it be said, on reasonable grounds, that the evidence shows that the RCMP as an organization, and in particular its senior officers, did not care? Can it be said that the RCMP showed wanton or reckless disregard for the safety of people in its custody, such as AP? In this case, it cannot. Rather, the evidence appears to show a significant degree of bureaucratic inadequacy – not so much wilful blindness to risk as failures of the organizational will to adequately minimize that risk through effective training, monitoring and quality control in the hiring, training and supervision of staff. Again, serious mistakes can be said to have been made, but not to the level that results in criminal culpability. Even with the mistakes, in the end, EHS was called, demonstrating the organization as a whole acted with a level of concern for AP.

Therefore, overall, on the evidence this case does not rise to the very high threshold required for a charge of criminal negligence causing death.

Accordingly, as the Chief Civilian Director of the IIO, I do not consider that there are reasonable grounds to believe that an officer, or any group of officers, or the organization of the RCMP itself, may have committed an offence under any enactment and therefore the matter will not be referred to Crown counsel for consideration of charges.

On a broader note, I have written in the past about the appropriateness of holding persons with substance abuse and physical ailments in police custody. I have suggested that for many such cases a form of secure health care facility would be more appropriate to ensure the safety of those individuals.

This case provides an opportunity for a discussion of additional steps that could be taken, most likely through changes to BC Policing Standards:

- The development of standardized training for all jail guards and officers responsible for prisoners that includes the dangers of substance withdrawal and other physical conditions, unconscious bias training, and ensuring accurate and fulsome recording in prisoner logs.

- Ensuring all police lockup facilities are regularly audited to confirm daily practice meets the required standards. This should include ensuring the senior officer in charge of the cells for each shift has properly carried out physical cell checks at the required intervals and communicated with guards about the individual health of each prisoner.

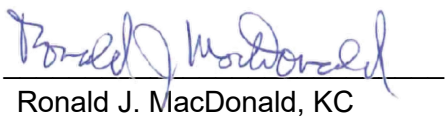
- Developing a standardized Prisoner Log which invites greater detail regarding the health and addictions issues of a prisoner, follow up actions, medications requested and given, meals provided and refused, and which encourages communication between guards and prisoners on these issues.

- Requiring formalized briefings at guard shift change and senior officer in charge shift change.

- For prisoners being held longer than 24 hours, consideration should be given to conducting health assessments by a trained medical professional after each 24-hour period.

- Consideration should be given to requiring audio recording of all areas where video recording is now required.

These improvements are suggested in an attempt to reduce as much as possible the incidents of death in police jail cell facilities.



Ronald J. MacDonald, KC
Chief Civilian Director

May 7, 2024
Date of Release