INDEPENDENT
Investigations Office of BC

IN THE MATTER OF THE DEATH OF A FEMALE WHILE IN THE CUSTODY OF THE VANCOUVER POLICE DEPARTMENT IN VANCOUVER, BRITISH COLUMBIA ON MAY 1, 2021

DECISION OF THE CHIEF CIVILIAN DIRECTOR OF THE INDEPENDENT INVESTIGATIONS OFFICE

Chief Civilian Director:	Ronald J. MacDonald, KC
IIO File Number:	2021-113
Date of Release:	August 2, 2023

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INTRODUCTION

On the morning of May 1, 2021, the Affected Person ('AP') was arrested on a warrant and taken into custody at Vancouver police cells. While in police custody, AP's medical condition declined, and this was brought to the attention of jail nursing staff. AP was cleared to be placed in a cell, but not long after, she was found unresponsive. Attempts to resuscitate her were unsuccessful.

Because AP's death had occurred in police custody, the Independent Investigations Office ('IIO') was notified and commenced an investigation. The narrative that follows is based on evidence collected and analyzed during the investigation, including the following:

- statements of three civilian witnesses (including two jail nurses), four first responders and seven witness police officers;
- police Computer-Aided Dispatch ('CAD') and Police Records Information Management Environment ('PRIME') records;
- audio recordings of 911 calls and police radio transmissions;
- video and photographic evidence;
- police vehicle data terminal download;
- ambulance patient care reports;
- Vancouver Police Department regulations; and
- autopsy and toxicology reports.

The IIO does not compel officers who are the subject of an investigation to submit their notes, reports and data. In this case, the Subject Officer has not provided any account to the IIO.

NARRATIVE

At 7:42 a.m. on May 1, 2021, the Affected Person ('AP') called 911, saying she had been drinking and was "thinking about committing suicide" by jumping from a bridge. Civilian Witness 1 ('CW1') later told the IIO that she saw police officers come to AP's suite and talk with her. CW1 said that AP was joking about jumping off a bridge and the officers told her it was not funny. CW1 said the officers dealt with AP in a caring way. About fifteen to

twenty minutes later, CW1 saw AP walk out with the officers and smoke a cigarette before being handcuffed and placed into the rear of a police vehicle. CW1 said she had no concerns for AP at that time.

The officers who first attended were the Subject Officer ('SO') and his field trainee, Witness Officer 1 ('WO1'). They were followed by WO2 and WO3. WO1 told the IIO that AP said she had been drinking "all night", but did not appear intoxicated, walking and talking normally. He said she was drinking cranberry juice; WO2 smelt the juice and said it did not smell as if it contained alcohol.

AP was not apprehended under the Mental *Health Act*, as it appeared she was not suffering from a mental disorder and did not appear to be serious about committing suicide. However, officers were aware that there was an outstanding warrant for her arrest, so she was taken into custody. The intention was to take her to a police facility for fingerprinting and then release her with a date to attend court.

WO2 and WO3 were also interviewed by IIO investigators, and gave similar accounts of AP's arrest. She was described as calm and cooperative, and was not noticeably intoxicated. She was able to walk unassisted to SO's police vehicle for transport. This was confirmed by IIO investigators after viewing video from the building where AP lived.

WO1 said that AP appeared to fall asleep in the back of the police vehicle, snoring audibly. He said that when they arrived at the Cambie Street police station and woke her, her speech was slurred and she could not stand up properly—she now appeared to be intoxicated. The officers asked her if she had taken drugs or alcohol and she denied doing so. They helped her into the station and sat her down in a chair. There was a technical problem with fingerprinting her and completing the necessary paperwork at Cambie Street, so SO told her she would have to be taken to the jail. WO1 said that AP responded and appeared to understand, but could not stand up when asked to do so.

Upon arrival at the jail, WO1 said, AP's condition had deteriorated to the point where it was necessary to get a wheelchair for her, and SO said he would have jail staff notify the nurse, so that AP could be medically cleared before being placed in a cell.

WO4, a Special Municipal Constable working as a jail guard, assisted, and took AP inside in the wheelchair, where WO5 was asked to help WO4 in searching AP. WO4 told investigators that nothing was said by SO about the change in AP's condition, or the need to have her seen by nursing staff.

WO5 told the IIO that AP was taken from the wheelchair and laid on the floor to be searched. She said that AP appeared drowsy, but was able to respond to officers.

WO6 also assisted at this stage, and later described AP as able to communicate but unable to stand. She did not complain of injury or ill health, WO6 said, so he concluded that she was intoxicated.

WO7, Acting Supervisor in cells at the time, described AP as appearing intoxicated upon arrival at the jail. WO7 said that AP was taken to a cell reserved for persons with mental health issues or other detainees that need staff to watch them more carefully. AP was placed in the recovery position on a mattress on the cell floor, said WO7, and was checked on every fifteen minutes.

CW2 was working as a part-time jail nurse at the time of the incident. As part of her duties, she and another nurse (CW3) were conducting alternating hourly checks on detainees. CW2 told IIO investigators that when she first checked on AP, she saw that she appeared fine. An hour later, CW3 said, she noted that AP was still alright. When CW2 next did her rounds, though, AP was blue and did not appear to be breathing. A guard let CW2 into the cell and she commenced CPR.

WO7 said that around noon, she heard a ‘Code Blue’ medical emergency broadcast. Going to AP’s cell, WO6 found staff performing chest compressions on AP. Paramedics attended and took over the life-saving procedures, but were unable to resuscitate AP.

Both CW2 and CW3 told the IIO that AP was not assessed by the nurses upon arrival at the jail. Prisoners like AP, who were arrested on a warrant rather than, for example, for breach of the peace or severe intoxication, would not usually be seen by a nurse. That would require a request from the involved officers.

The autopsy report for AP indicated cause of death as “complications of cirrhosis of the liver with combined prescription drug and alcohol intoxication”. Toxicology was negative for illicit substances and no significant traumatic injury was noted. The opinion of a medical expert consulted by the IIO suggests that medical intervention may have helped AP, if provided at a critical point, but the onset of death was sudden and would have been difficult to reverse.

LEGAL ISSUES AND CONCLUSION

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.

In a case such as this one, involving the potential offences of criminal negligence causing death or failure to provide necessaries, including medical assistance, to a person in police custody, one of the threads of the IIO investigation will be the gathering of evidence about whether officers met the relevant standard of care. In order to constitute criminal negligence, the actions of an officer 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. A charge of failing to provide necessaries, on the other hand, would be based on a somewhat lower threshold – a 'marked departure' from the conduct of a reasonably prudent police officer where a risk of danger to the detainee was objectively foreseeable. These are significant tests, as Canadian criminal law does not sanction 'ordinary' negligent errors, just very significant ones that therefore justify a criminal sanction.

AP's death was evidently a result of longstanding lifestyle issues, and it is not clear that medical intervention would have altered the outcome for her. Having said that, though, it was the duty of all involved officers to do what they could to protect her from harm. SO was in the best position to observe that her condition had changed quite significantly, and that observation should have caused him to seek medical attention for her urgently. As

he has not provided any account to investigators, there is no evidence that he passed on any concerns to any jail guard or nurse.

As the Ontario Court of Appeal stated in a recent case involving the death of a person in police custody, the question is not, strictly, whether the detainee's medical condition had actually deteriorated:

> *The question was whether the changes evident in her condition would have caused a reasonably prudent police officer to seek out the advice and assistance of those with the necessary medical training to properly assess the significance of the observed changes and provide any further needed medical response*[1]*.*

SO, as the responsible investigating officer, must have observed the change in AP's condition between the time of her arrest and her arrival at the jail, as it was significant. There is no evidence he took steps to ensure nurses on staff were alerted to ensure AP was assessed by a medically trained person. This would appear to fail the test set out by the Ontario Court of Appeal. That failure may have been, to some extent, the result of miscommunication, given WO1's evidence that SO did intend to convey a message to a nurse. However, without evidence from SO, it is not clear why neither of the nurses was notified. In these circumstances, this strongly suggests a failure by SO to seek medical attention for AP as required by the duty to provide necessaries of life.

However, the law requires that the failure to seek that attention would have caused AP's life to be endangered. The law does not require proof that the person would have survived with such attention, only that any delay would have increased the chances the person would die.

In this case, the evidence is not sufficient to show any delay would have mattered, as the medical evidence suggests AP could very well have died regardless, even if a nurse had checked her upon arrival and sent her to hospital. Additionally, both nurses who observed AP while she was in the cell felt that she was simply intoxicated rather than sick. It is possible they would have reached the same conclusion when she was brought in, even if they had been told that her condition seemed to have worsened while being transported.

Thus, even though the evidence is strongly suggestive that SO failed in his legal duties, it cannot be shown it created any additional harm to AP that was not already inevitable.

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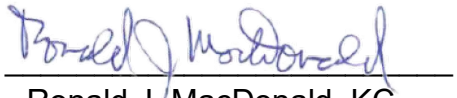
[1] *R. v. Doering*, 2022 ONCA 559, at para. 60

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



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