IN THE MATTER OF THE DEATH OF A MALE
WHILE IN THE CUSTODY OF THE RCMP
IN SURREY, BRITISH COLUMBIA
ON JULY 2, 2021

DECISION OF THE CHIEF CIVILIAN DIRECTOR
OF THE INDEPENDENT INVESTIGATIONS OFFICE

Chief Civilian Director:	Ronald J. MacDonald, KC
IIO File Number:	2021-172
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INTRODUCTION

The Affected Person ('AP') was arrested by Surrey RCMP on July 1, 2021. He was held overnight in Surrey RCMP cells for a court appearance the next day. After being out of his cell several times for calls to legal counsel during the morning of July 2 without any difficulty, AP suddenly exhibited medical distress and paramedics were called. Unfortunately, they were unable to resuscitate AP, who was declared deceased after about thirty minutes of life-saving attempts. Because the 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 five civilian witnesses, four first responders and one witness police officer;
- police Computer-Aided Dispatch ('CAD') and Police Records Information Management Environment ('PRIME') records;
- RCMP detachment cell block records;
- audio recordings of 911 calls and police radio transmissions;
- video recordings from the area of AP's arrest and from the RCMP detachment;
- BC Emergency Health Services records;
- review of RCMP policies;
- autopsy report; and
- analysis and opinion from expert in emergency medical care.

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

In the early afternoon of July 1, 2021, the Affected Person ('AP') was arrested in Surrey after assault complaints were relayed to police. He tried to run from the officers and was taken to the ground to be handcuffed. The incident was recorded from a significant distance by a security video camera. There is no evidence that any excess force was

used by officers, or that strikes or kicks were used during the arrest. AP did not complain of any injury afterwards, and he did not appear to be under the influence of intoxicants.

AP was transported to the Surrey RCMP detachment, where he was searched quite thoroughly for any contraband and none was found. He was taken to see the detachment nurse to be cleared for custody, and was then given an opportunity to speak by phone with legal counsel. He was remanded for a video court appearance to be held the following day, and was lodged in a cell. Detachment records indicate that he had no injuries, and did not require any medication.

On the morning of July 2, AP is recorded as having complained that his stomach hurt, and he was provided with antacid tablets. The night-shift nurse had left Tylenol and Gravol to assist him with drug withdrawal, but AP declined these medications and took the antacids instead.

AP was escorted from the cell several times during the morning to speak with courthouse duty counsel. After the last occasion, he was placed back in the cell at 10:08 a.m. Cell video shows him sitting or lying on the bench, apparently sleeping intermittently. At 12:08 p.m., he is seen to get up and appears to vomit into the toilet, before returning to the bench and going back to sleep.

Just after 12:22 p.m., AP sits up, collapses over onto his right side and then rolls off the bench onto the floor. The video shows him making very slight movements for the next approximately one to two minutes before becoming motionless with his head pressed into the angle between the bench and the cell wall, twisted sideways at an unnatural angle.

Over the next half hour or so, detachment staff members made observations of AP as he lay on the floor in that manner:

- 12:23 p.m. - the Subject Officer ('SO') is seen on hallway video approaching the cell door and looking briefly into the cell through the door's observation window before walking away.
- 12:25 p.m. – Civilian Witness 1 ('CW1'), a civilian jail guard, also looks in through the window for a few seconds before leaving.
- 12:40 p.m. – CW1 again looks in, for about five seconds.
- 12:56 p.m. – CW2, a second civilian guard, observes AP through the viewing window, for about 19 seconds. He then appears to go to an office area where a supervising non-commissioned RCMP officer ('NCO') is situated.

- 1:05 p.m. – the NCO is seen on video approaching AP's cell, stopping momentarily at another cell on the way. At AP's cell, the NCO looks in and then opens the cell door and enters. He nudges AP's leg with his foot, apparently attempting to rouse him, and then leaves the cell.

- 1:06 p.m. – the NCO returns to the cell, having retrieved gloves and summoned the assistance of SO.

- 1:08 p.m. – first aid commences, principally administered by SO.

- 1:14 p.m. – first responders (initially firefighters) arrive to take over resuscitation attempts.

- 1:46 p.m. – life-saving attempts cease, on the advice of an on-call emergency physician.

CW1 later told IIO investigators that on the day of AP's death there was no nurse on duty at the detachment. Any medical concerns were to be relayed to the cells NCO.

CW1 recalled checking on AP during a round of cell checks ending at 12:40 p.m., and said that AP was on the floor at that time. CW1 said that he did not recall anything having been concerning about AP's demeanour, orientation or breathing. Asked if he thought the position in which he had seen AP was unusual, CW1 said he was "not certain". He said that CW2 checked on AP during the next round of checks, and summoned the NCO, who directed CW1 to call for medical assistance.

CW1 said his understanding was that if a cell check indicated that a prisoner was breathing and moving, it was deemed a satisfactory check, regardless of the physical position the prisoner was in. He also said that, while monitoring cell video, he had not seen AP's fall from the bench onto the floor.

CW2, in his IIO interview, described checking AP's cell and observing him on the floor with "shallow breathing". He said that, as this was a change in AP's condition, he advised the NCO, as required by policy.

CW2 also said that, earlier in the day, he had been observing AP by video and had seen him vomiting. He said he had brought this to the attention of SO and the other guards.

At post-mortem, AP was found to have no external injuries other than numerous skin ulcers and injuries to the chest consistent with attempts at resuscitation. There was extensive scar tissue around the lungs and heart, AP's heart was enlarged and there was swelling of his brain (cerebral edema). His liver was found to be fatty and swollen. His blood tested positive for methamphetamine and fentanyl.

The IIO sought an expert medical opinion from an experienced emergency room physician. The doctor was asked a number of questions based on the evidence in the case, focussing principally on whether earlier medical attention might have saved AP's life.

The expert provided a careful and detailed analysis of the evidence, and concluded that AP suffered cardiac arrest at the time he is seen on video slumping to the cell floor:

> *It is probable that at this time his chronically dilated and weakened heart, further stressed and rendered irritable by methamphetamine, suddenly transitioned from a functional regular heartbeat to a lethal arrythmia, most likely ventricular fibrillation.*

In such a situation, the expert stated, "[d]eath ensues quickly in the absence of timely and definitive resuscitation".

Asked specifically whether such an attempt at resuscitation might have been successful if SO had intervened immediately at 12:23 p.m., the expert responded in the negative:

> *While this check occurred only 72 seconds after cardiac arrest, it is my opinion that even if [SO] had immediately realized that [AP] was in medical distress requiring rapid attention, any action he could have taken would have proved futile.*
>
> *Such a pessimistic view follows from [AP's] premorbid condition and the setting in which the cardiac arrest occurred. While [AP] was relatively young … he was not a well man. Autopsy revealed the presence of a dilated cardiomyopathy, i.e., an enlarged and weakened heart. This was likely secondary to chronic substance use, in particular alcohol and methamphetamine; methamphetamine was present on toxicology analysis, and paramedic notes plus the autopsy findings of a swollen fatty liver and dilated cardiomyopathy are in keeping with chronic alcohol use.*
>
> *…*
>
> *Given that his cardiac arrest occurred in locked cells, I am virtually certain that [AP] stood no realistic chance of survival from the moment he collapsed into cardiac arrest. Even if [SO] had concluded that [AP] needed urgent medical help [at 12:23 p.m.], he would still have had to contact colleagues and mount a case for their immediate assistance … and they would have had to attend and commence their own assessment.*

In summary, the expert's opinion was that AP's life could only, potentially, have been saved if professional medical assistance had been provided urgently and effectively, within a time post-collapse that was simply unrealistic given the circumstances.

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.

The Subject Officer here was under a statutory duty to provide 'necessaries of life' to any person under his charge. In this context, 'necessaries' include provision of necessary medical care, and a failure to perform the duty is an offence if the failure endangers the life of the person. The offence is one involving negligence—a failure to act—and the standard of care in the case of police can usefully be gauged by reference to police policies and practices, which require any member of detachment custodial staff to call for medical assistance whenever a detainee exhibits signs of medical distress. That was not done here—at least, not by CW1 or by SO.

The failure on CW1's part is not a matter that falls within IIO jurisdiction. He was not, at the material time, an 'officer' as defined in the *Police Act*. SO was, of course, as he was a police constable.

It was not reasonable for either of those individuals, observing AP through the door window after he fell from the bench, to think his bodily position was normal. It would have been apparent to any reasonable observer that AP was in need of assistance. Failure to

summon aid was a failure to live up to the requirements of RCMP policy, and a negligent failure to meet the standard of care. In the case of SO, then, the question is whether his negligence amounted to the criminal offence of failing to provide necessaries of life.

That offence, which is set out in section 215 of the *Criminal Code*, includes a further element regarding the consequences of the officer's failure. As mentioned above, the evidence must show (in a case such as this one) that the detainee's life was endangered. That further requirement is what motivated IIO investigators to seek the expert medical opinion referred to above.

As noted, the expert's opinion was that, even at the time SO looked into the cell; saw that AP was on the floor with his head in a particularly unusual and awkward position; but did not immediately enter the cell or seek assistance, it was almost certainly too late to save AP's life. The evidence, in other words, is that SO's failure did not endanger AP's life, so did not amount to a criminal offence.

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.

Martin Allen, General Counsel for
Ronald J. MacDonald, KC, Chief Civilian Director

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