INDEPENDENT
Investigations Office of BC

IN THE MATTER OF THE DEATH OF A MALE WHILE IN THE CUSTODY OF THE RCMP IN SURREY, BRITISH COLUMBIA ON APRIL 16, 2022

DECISION OF THE CHIEF CIVILIAN DIRECTOR OF THE INDEPENDENT INVESTIGATIONS OFFICE

Chief Civilian Director:	Ronald J. MacDonald, KC
IIO File Number:	2022-080
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Introduction

On the morning of April 15, 2022, the RCMP were called to an incident where they arrested the Affected Person ('AP') without incident. AP was taken to Surrey RCMP cells, where he died the following day while he was in 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 six civilian witnesses;
- statement of one witness police officer;
- video of AP's arrest;
- CCTV video from RCMP cell block;
- prisoner logs from RCMP cell block;
- police Computer-Aided Dispatch ('CAD');
- Police Records Information Management Environment ('PRIME') records;
- scene examination;
- BC Emergency Health Services records;
- medical records;
- expert medical opinion; and
- autopsy report.

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

Narrative

On April 15, 2022, the Surrey RCMP received a call from Civilian Witness 1 ('CW1') who asked for police assistance for an assault in progress.

RCMP officers attended and found the Affected Person ('AP') at 9:40 a.m. Civilian Witness 2 ('CW2') was present when AP was being arrested and recorded his arrest on her cell phone. AP was seen on the video to be compliant with the officers' instructions and no force was used by the officers on AP.

AP was transported to the RCMP detachment in Surrey. At approximately 11:00 a.m., AP arrived at the RCMP detachment. The CCTV video recordings show that AP was

searched and was compliant and engaged with officers during his booking process and during the times he was taken out of cell to make phone calls.

AP became increasingly agitated later that night and into the early morning hours of April 16, 2022. He was seen on the CCTV video recordings and appeared to be yelling with agitated body language. He also threw items at the in-cell camera, tried covering the cell windows, and tried to flood his cell.

Witness Officer 1 (‘WO1”) had a discussion with AP about his behavior. WO1 told the Subject Officer (‘SO’) that AP had threatened him during that discussion and that he wanted to fight police. Because of the change in AP’s behaviour, it was decided by SO that WO1 should not go into the cell alone, and two officers would be required to go inside AP’s cell for safety reasons. SO was the senior officer and responsible for the oversight of the cells that evening.

At 6:24 a.m., AP appeared to pull something from under his mattress, which the investigation has determined was likely drugs. AP laid face down and pulled the blanket over himself, turning his face toward the wall. From viewing the CCTV video recordings, it appeared that AP possibly ingested drugs on three further occasions, all while his back was turned away from the view of the CCTV cell camera. By 10:01 a.m., AP appeared still and sleeping.

The jail cells were monitored by civilian jail guards, who are required to perform checks on prisoners every 15 minutes by walking around the cells and viewing them from the external hallway to their cells. The IIO’s jurisdiction to investigate does not extend to investigating the actions of the civilian jail guards.

Civilian jail guards are not permitted to enter prisoners’ cells. As per RCMP policy, if civilian jail guards become aware of a health or safety issue, they are to inform the police officers, who are then required to enter the cell.

A review of the prisoner logbooks showed that the required checks were performed by the civilian jail guards, and that AP was observed to be laid on his front and breathing. There are no recorded entries in the logbook that suggested there were concerns about AP’s health until after 2:00 p.m. that day.

At 2:06 p.m., Civilian Witness 3 (‘CW3’) did a check and noted AP had been in the same position for an extended period of time. CW3 made noise, and knocked repeatedly on the cell door in attempts to rouse AP, but did not observe a response.

CW3 returned to the guard station and informed WO1 of his concerns and requested WO1 check AP. CW3 and WO1 walked over to AP’s cell together at 2:08 p.m., and again made noise, but did not get a response from AP. WO1 stated that he needed a

second officer in order to enter the cell, and that SO was not in the cell block area at that time. At 2:21 p.m., CW3 tried to rouse AP again from outside the cell, but still did not receive a response.

At 2:22 p.m., WO1 hit and kicked the door again, but still did not receive a response. CW3 said that WO1 thought he saw AP breathing and that he was most likely in a deep sleep.

Between 2:00 p.m. and 2:13 p.m., SO was absent from the cells, returning at 2:13 p.m. WO1 is observed speaking to the SO at 2:23 p.m. It is not clear what is being discussed, as the CCTV video recordings do not have audio. WO1 said that he discussed the concern about AP with SO, and that SO had brought AP up on his computer screen and told WO1 that the AP was fine.

Civilian Witness 4 ('CW4') was another jail guard working in the cells. CW4 also requested that WO1 and SO do a physical check of AP.

The CCTV shows that it was not until ten minutes after SO spoke to WO1, at 2:33 p.m., that WO1 and SO entered AP's cell. WO1 approached AP and found him unresponsive. SO left the cell and returned moments later with a cell nurse. Officers performed chest compressions on AP, which continued until first responders arrived and took over. AP was provided with measures attempting his resuscitation until 3:24 p.m. when a physician was consulted over the telephone, and AP was pronounced deceased.

An autopsy was performed, and the cause of death was determined to be an overdose of fentanyl, methamphetamine and benzodiazepines with no other contributing factors. During autopsy, a foreign object (plastic wrapped around tinfoil) was found in AP's rectal cavity, which was tested and confirmed to be cannabis.

The IIO sought an expert medical opinion from an emergency physician. The medical expert was consulted to obtain a better understanding of when AP died, and to assess whether earlier action by the officers could have saved AP's life. The medical expert said that the combined effects of fentanyl and benzodiazepines led to respiratory arrest, and that the heart, deprived of oxygen, would have stopped beating approximately ten minutes after that.

The medical expert said that AP likely died several hours before officers were alerted by the jail guards that there was an issue. Based on the medical expert's review of the evidence, he concluded that AP went into cardiac arrest by 12:00 p.m. latest. The medical expert concluded that "*any attempt to resuscitate him after 12:30 hours was futile and doomed to failure*".

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 potential negligence offences, one of the avenues of the IIO investigation is gathering evidence about whether officers met the relevant standard of care. In order to constitute the offence of 'failing to provide the necessaries of life' under section 215 of the *Criminal Code*, the actions of an officer would have to fail to meet the standard of care by criminal standards. Officers' actions must be a marked departure from the standard of care in order to constitute an offence.

In this context, 'necessaries' include provision of necessary medical care for AP. The definition of the offence under section 215 also includes a 'consequences' element. In other words, a negligent failure on the part of an officer only becomes criminal if the actions endanger the life of AP or causes the health of AP to be injured permanently.

Police interactions with AP were largely captured on video, including throughout the transportation and booking-in process, and in RCMP cells. During all of those interactions, there was no inappropriate use of force at any stage, and officers acted in a professional manner.

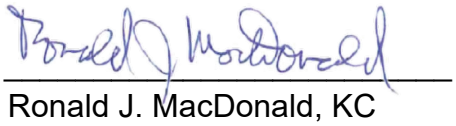
While AP was in the cell, monitoring was carried out, as recorded and corroborated by video and prisoner logbook evidence. Although their checks of AP may not have been as thorough as they could have been, given the opinion of the medical expert.

One observant jail guard, CW3, notified WO1 when he became concerned after noticing that AP was lying in the same position for a long time. Officers did not appear to act with urgency once notified, as it took them 10 minutes to collectively go to open the cell.

Given that those who are housed in cells are often from high-risk backgrounds, once provided with information regarding a concern for the wellbeing of AP, the response from SO and WO1 should have been almost immediate. In certain circumstances, this could have the potential to constitute the required amount of fault to be an element of an offence under section 215 as discussed above. However, the medical expert estimated that AP was likely deceased hours before he was provided with medical attention. No resuscitation attempts would have saved him at the point that officers were notified by the jail guards of his condition. Therefore, even if the failure of police to act more quickly met the test for the required degree of fault, any such inaction could not have made any difference in this case and did not endanger AP's life.

Unfortunately, AP died from ingesting drugs in his cell, and a faster response in providing medical attention to AP once officers were alerted to his condition would not have saved his life.

Accordingly, as the Chief Civilian Director of the IIO, I do not consider 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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