INDEPENDENT
Investigations Office of BC

IN THE MATTER OF THE DEATH OF A MAN WHILE IN THE CUSTODY OF THE RCMP IN SMITHERS, BRITISH COLUMBIA ON SEPTEMBER 4, 2022

DECISION OF THE CHIEF CIVILIAN DIRECTOR OF THE INDEPENDENT INVESTIGATIONS OFFICE

Chief Civilian Director:	Jessica Berglund
IIO File Number:	2022-237
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INTRODUCTION

On September 1, 2022, the Affected Person ("AP") was arrested on charges related to an alleged home invasion. He was lodged in Smithers RCMP cells over the Labour Day long weekend and scheduled to be transported to the remand centre in Prince George the following Tuesday, September 6. On the evening of September 4, the AP was found unresponsive in his cell. He had hung himself with a noose made from a pair of tube socks.

Because the AP's death had occurred while he was 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 nine civilian witnesses, one paramedic and nine witness police officers;
- police Computer-Aided Dispatch ("CAD") and Police Records Information Management Environment ("PRIME") records;
- audio recordings of police radio transmissions;
- video recordings from the Smithers RCMP detachment;
- scene and exhibit examination and photographs;
- data downloaded from a police vehicle mobile data terminal;
- RCMP policies;
- RCMP detachment records;
- Commissionaires BC records;
- B.C. Emergency Health Services records;
- Fire-rescue service records;
- medical records; and
- autopsy and toxicology reports.

NARRATIVE

On the evening of Thursday, September 1, 2022, the Affected Person ("AP"), who was Indigenous, was arrested by Smithers RCMP and charged with aggravated assault in connection with an alleged home invasion.

While the AP was being transported to the detachment after his arrest, he was audio-recorded by Witness Officer 1 ("WO1") saying that he was ill and dying, and that he used drugs and alcohol to deal with the pain. He expressed distress that he was dying at a young age. The AP provided the officer with details about his medical issues and told him that he would need his medications. Chapter 19.3 of the RCMP's national operational manual requires any medical information known by the police to be documented on an intake form known as a Prisoner Report Form or C-13. The C-13 form filled out by WO1 with respect to the AP included a section for the officer to record "Illnesses/Pre-Existing Medical Condition," but it was left blank. The form also required the officer to note any concerns over "State of Mind," but that section was also left blank.

The same chapter of the operational manual also requires the arresting officer to brief the jail guard on duty about any issues suggesting enhanced care is required, such as the detainee's emotional and medical condition and any injuries, but there is no evidence that this was done by WO1 or by any other officer.

On September 2, the AP was brought out of his cell on four occasions: for calls to his lawyer, for an interview and fingerprinting, and for his bail hearing. He was accompanied to the telephone room for the lawyer call by Witness Officer 2 ("WO2"). At the bail hearing, which was held virtually, the AP was ordered to be remanded in custody in Smithers cells until Tuesday, September 6, after the long weekend.

WO2 told the IIO that the reason the AP was held longer than usual at the detachment was that transport by sheriffs to the remand facility in Prince George was only available on a fixed schedule, and the earliest available day following the AP's bail hearing was the Tuesday following Labour Day.

On September 2, the AP gave a statement to Witness Officer 3 ("WO3") about the incident that led to his arrest and his personal circumstances. The AP told WO3 that he was dying and had only a couple of months to live. He told her he was in pain and needed prednisone and Tylenol 3 that had been prescribed for him by his physician. Following the conversation, at 9:35 p.m., WO3 wrote in the cell logbook, "[WO3] provided 2 Tylenol b/c of confusion @ pharmacy and it's now closed." The detachment did not have prednisone on hand as it is a prescription medication. WO3 asked the AP's family to bring in the medication but the family was unable to locate it.

On the afternoon of September 3, the AP complained of feeling unwell so was taken by Witness Officer 4 ("WO4") to the hospital, where he was prescribed prednisone for pain. He was then returned to cells.

On September 3, jail staff gave the AP a change of clothes including a hoodie, with the drawstring removed, and tube socks. These items had been dropped off for him at the detachment by a family member. WO3 told the IIO that she gave permission for the clothes to be given to the AP but did not inspect them.

Supplemental policies applicable to the Smithers RCMP detachment state that if a prisoner in a cell removes any article of clothing, the item must be removed from the cell and placed with the prisoner's personal effects. As noted below, for a significant time it was visible on cell video that the AP had removed his tube socks and was barefoot. No action was taken by any staff member to remove the socks, which the AP was subsequently able to use to self-harm.

The AP was also given two prednisone tablets, prescribed for him earlier at the hospital and picked up by WO4. The cells logbook was updated with an entry saying the AP had received five Dilaudid (hydromorphone) painkillers at 9:30 p.m. The investigation determined that this entry was made incorrectly, as video evidence does not show the AP being given any medication at the noted time, and the toxicology tests did not detect the presence of hydromorphone or its derivatives. The AP did receive prednisone as prescribed on the evening of September 3 as well as the next morning, September 4.

The last time that any police officer conducted a physical check on the AP was at 7:57 a.m. on September 4. Witness Officer 5 ("WO5"), who was responsible for guard duties that morning between 5:55 a.m. and 8:00 a.m., visited the cells area just before going off shift. No other police officer checked on the AP in his cell after that until he was found, unresponsive, 13 hours later.

Starting at 8:00 a.m. on September 4, Civilian Witness 1 ("CW1") was on duty as a jail guard, and Civilian Witness 2 ("CW2") took over that role at 4:00 p.m. At about 5:51 p.m., CW2 provided a meal to the AP through an opening in the cell door, which is below the inspection port, consisting of a slot with a hinged metal plate designed to cover it when closed. Apart from that attendance at the cell door, CW2's monitoring of the AP was restricted to sitting at his guard station (only a short distance from the AP's cell door, but not within sight of it), where there were video monitors showing the cell interiors.

The following is based on the video recordings from cameras showing the cell, the corridor outside the cell and the guard station itself:

- Before CW2 brings the meal at 5:51 p.m., the AP is mostly lying on the cell bench, moving around or appearing to sleep. The bench has a sleeping mat on it, and the AP has a blanket. He is dressed in dark-coloured pants and a dark hoodie, which

is pulled up over his head. His feet are bare. At various times, there appears to be a pair of white socks beside him or under him.

- At 5:37 p.m., the AP appears to be eating and is seen to go to the cell door at 5:52 p.m. to pick up a plate and cup. He returns to the bench, continuing to eat.

- From 6:04 p.m. to 6:54 p.m., the AP is lying on the bench, moving around under the blanket. He then gets up, walks over to the cell door and sits down next to it. He appears to be looking out through the meal slot.

At about this time, CW2 has evidently observed by video from his guard station that the AP has moved from the cell bench to the floor and makes a note in the logbook that reads "floor."

- From 6:54 p.m. to 7:27 p.m., the AP remains sitting by the door, reaching through the meal slot several times. At times, he crouches down and appears to be manipulating something in his hands, possibly placing something over his head inside the hoodie (at 6:58 p.m., in the video of the hallway outside the cell, the AP's hands can be seen reaching out through the food slot holding something white, but it is not possible to determine from the video what he is doing). CW2 does not appear to notice any of these actions by the AP and does not react to them.

- At 7:27 p.m., on hallway video, one of the AP's hands can be seen reaching through the food slot for the final time.

- At 7:28 p.m., the AP appears to reach behind his head as he curls up on the floor with his back against the cell door.

- At 7:31 p.m., the AP straightens out his legs on the floor. A white line can be seen running from the food slot to the area of the AP's neck or head, which is still covered by the hoodie. The AP's arms are moving around.

- At 7:33 p.m., the AP's arms come to rest in front of him and he stops moving.

- At 7:36 p.m., there is a slight movement of the AP's lower leg, which is the last movement seen on the video.

- At 8:58 p.m., almost an hour and a half later, a light is seen shining through the food slot.

- At 9:00 p.m., the cell door opens, WO1 peers inside and then pulls the AP out of the cell to begin CPR attempts.

For the majority of the period set out above, recordings from the video camera directed at the guard station show that CW2 was either sitting in front of the monitoring screens with his feet up on the counter, appearing to be nodding in and out of sleep, or turned away from the screens, apparently browsing on a computer. He can be seen occasionally

writing. At no point does CW2 conduct any physical checks on the cells as required by RCMP policy.

At 8:58 p.m., CW2 is seen to go to the AP's cell door. He knocks several times and peers in through the food slot. He then appears to go to summon officers, who open the cell door, pull the unresponsive AP out into the hall and cut the knotted tube socks from around his neck. They commence resuscitation attempts and call for paramedics to attend.

At the time of this incident, the IIO did not have jurisdiction over jail guards and CW2's actions were investigated by the RCMP. CW1, interviewed as part of the RCMP investigation, said that it was known in the detachment that the food slot flaps were defective. He said they were left open because they would get stuck if they were closed, and staff would have to use a claw hammer to open them.

CW1 also acknowledged the routine failure by staff to conduct physical checks of cells as required by policy. He said that physical checks were made if there was a person in the "drunk tank," but not for a detainee in a regular cell like the AP. Any checking on those prisoners, he said, was done remotely by video.

Speaking of the day the AP died, CW1 said he remembered telling CW2 that he should really watch the AP, who he said was "restless" and holding his stomach as if in discomfort. CW1 told the IIO that when CW2 came on shift, CW1 warned him that the AP's behaviour had changed and that he needed to be watched carefully.

Interviewed by the IIO, CW2 recalled taking the AP a meal, and then noticing that he was "right down against the door." CW2 said that he was using the CCTV to watch the AP over the next "couple of hours," and then went to the cell to give the AP a pack of playing cards. When he yelled but got no response, he said, he went and got officers to come and assist.

CW2 said that the AP had been able to loop his knotted socks around the meal slot flap, which had been left open. CW2's evidence about the flaps was similar to CW1's evidence. He said that "everyone" knew the flaps were almost always left open, because they jammed if pushed shut, and were not repaired until after the AP's death.

CW2 told the IIO that he was the trainer for the Smithers RCMP detachment. He said he was aware RCMP policy called for physical checks of prisoners by the guards to be carried out every fifteen minutes, and that there was a column in the logbook that was to be ticked for each physical check. He added, however, that those policies had not been followed at Smithers detachment for 26 years. Further, CW2's recollection was that almost no checks were done by officers. Checking on the prisoners could lead to "problems," he said, like a prisoner asking for something. There had been several audits of the cells, CW2 said, and it had never been noted that cell checks were not being done.

CW2 said he believed the latest review of the cells operation was in March 2022, about six months before the AP's death. CW2 said he had been told, unofficially, that the reviewer had commended him for running "a tight ship" in the cell block.

CW2 told IIO investigators that he felt like he was being scapegoated. He said everyone at the detachment knew the cell checks were not being done, that the food slot flaps were left open, and that prisoners were allowed to be off the bench (where they could not easily be seen). The cells, CW2 said, were the responsibility of the detachment commander.

The regular detachment commander was Witness Officer 6 ("WO6"), but as mentioned above, during the time the AP was in custody, WO6 was away and WO3 was the acting commander.

Witness Officer 7 ("WO7") was the District Advisory Non-Commissioned Officer, responsible for guidance and oversight of seven detachments. He told the IIO that at the time the AP was in custody in Smithers, WO3, a corporal, had been made acting sergeant because the sergeant was on long-term leave. WO3 had then been made acting detachment commander because WO6 was away.

As acting detachment commander, WO3 said she was fulfilling the duties of corporal, sergeant and acting detachment commander and was dealing with a lack of both police and guard resources, file work, and managing two back-to-back major events. WO3 had been posted to Smithers since July 2021 and previously worked at other RCMP detachments in the province. When asked for her impression of the cells in Smithers compared to other detachments, WO3 said that cells were managed differently in other detachments, and that there was less interaction between the guards and prisoners in Smithers as well as fewer physical checks. Common to Smithers and other detachments that WO3 had worked in was that the guards were getting progressively older with attendant mobility issues.

The RCMP had conducted a managerial review of the Smithers detachment in March 2022, which included a review of the cell block. WO6 told the IIO that the review concluded that the cell block was "doing well," with no issues identified.

As noted above, the regular detachment commander in Smithers at the time of the AP's death was WO6. Interviewed by IIO investigators, WO6 confirmed that there is RCMP policy at the national, divisional and detachment levels regulating the safeguarding of prisoners. New members, he said, could learn the policies online and could read printed copies in a binder at the detachment.

RCMP policy designates the detachment commander as the officer ultimately responsible for ensuring that all personnel are familiar with policies connected with prisoner care. The civilian jail guards were hired and trained by Commissionaires BC. WO6 said that a new guard would receive one day's training from an in-house trainer. In the case of the

Smithers detachment, CW2, who had worked there for about 25 years, was the trainer. WO6 said there was supposed to be refresher training for guards every six months, and as detachment commander he was responsible for making sure it was done. He acknowledged that the refresher training had not been done but said he did not know why. WO6 said he was also responsible for making sure documentation such as the cells logbook was being completed properly, and for ensuring that the cells themselves were physically maintained. He said he knew that the cell food slot flaps were defective (jamming in the open position) but did not know how long that had been the case. WO6 confirmed that at the Smithers detachment there was no system in place to ensure that cell checks were being conducted according to policy.

Since the AP's death in Smithers cells, WO6 said he had ensured that everybody had read and "signed" the policy. In a follow-up interview in June 2023, WO6 stated that:

- he had made certain that the food slot doors were operational and that they remained closed unless opened to pass through food or clothing;
- he had been monitoring the cells logbook to make certain that all required cell checks were being conducted and that "physical" checks were made in person;
- the logbook had been improved to allow more detailed notes to be entered, particularly about what was observed in the cell;
- guard training had been brought up to date by a trainer from the Commissionaires; and
- more guards had been hired, and he had made it clear that all members must take responsibility for safety in cells.

CAUSE OF DEATH

The AP's autopsy report indicates cause of death as "asphyxia due to or as a consequence of hanging" and notes "other significant conditions contributing to the death" as methamphetamine and fentanyl toxicity.

ANALYSIS

The Independent Investigations Office of British Columbia is mandated to investigate 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 an investigation is complete, they can trust the IIO's conclusions, because the investigation was conducted by an

independent, unbiased, civilian-led agency. In most 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 may have committed an offence in connection with the incident. In such a case, the *Police Act* gives the CCD authority to refer the file to the BC Prosecution Service ("BCPS") for consideration of charges.

As mentioned above, at the time of this incident, the IIO did not have jurisdiction over jail guards and CW2's actions were investigated by the RCMP. In 2025, the *Police Act* was amended to bring jail guards under the jurisdiction of the IIO.

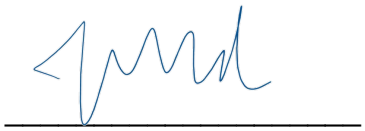
The evidence gathered in this investigation demonstrates that, at the time of the AP's detention and death, there were a number of failures in the cell block operations at the Smithers RCMP detachment. While CW2 did not meet the standard of care expected of him, the evidence is that his failures had been condoned for some time by detachment officers, who also appear to have been negligent in other aspects of prisoner care. Further, the evidence indicates that no action had been taken by senior officers in RCMP management to correct longstanding failures to follow policy with respect to the safeguarding of prisoners.

Simple negligence is not an offence under Canadian criminal law unless it meets the standard of criminal negligence causing death. For that offence to be proven, the actions of an individual or organization must fail to meet the required standard of care in a marked and substantial way, such that the actions demonstrate a wanton and reckless disregard for human life and the negligence must have caused the victim's death. The officers' actions in this case do not meet that test.

In the years 2019 to 2023 inclusive, the IIO was notified of six incidents in which detainees died while in police cells, and nine more in which prisoners were taken to hospital from cells and subsequently died there. Of those 15 deceased detainees, seven were Indigenous. These statistics clearly underline the importance of proper care of detainees by jail staff - care that was not provided in this case to the AP, a detainee who was clearly vulnerable and in need of close attention.

Sadly, there are similarities between this incident and IIO file 2022-258, in which an Indigenous AP died in cells in Williams Lake on October 1, 2022, less than a month after this incident. In both cases, adherence to RCMP policies and procedures intended to safeguard the well being of prisoners was found to fall below an acceptable standard.

The AP's death was tragic and could have been prevented. However, as 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 the matter will not be referred to the BCPS for consideration of charges.



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