



**IN THE MATTER OF THE DEATH OF A MAN
WHILE IN THE CUSTODY OF THE RCMP
IN WILLIAMS LAKE, BRITISH COLUMBIA
ON OCTOBER 1, 2022**

**DECISION OF THE CHIEF CIVILIAN DIRECTOR
OF THE INDEPENDENT INVESTIGATIONS OFFICE**

Chief Civilian Director: Jessica Berglund

IIO File Number: 2022-258

Date of Release: October 9, 2025

THIS PAGE INTENTIONALLY LEFT BLANK

The report of the civilian monitors in this matter, appointed in partnership with the T̓silhqot̓in National Government, was published on October 9, 2025, the same date as this public report. It can be found on the [publication page of the IIO's website](#).

INTRODUCTION

During the late evening of September 30, 2022, the Affected Person (“AP”) came to the attention of Williams Lake RCMP members while driving an unlicensed moped around Williams Lake. At the time, the AP was known to be prohibited from operating a motor vehicle. After a series of attempts by police to pull the AP over, an officer arrested both the AP and his female passenger. While one officer drove the passenger to her home, another took the AP to RCMP cells, where he was booked in and apparently fell asleep on the bench in his cell. About two hours later, the AP fell off the bench onto the floor. A guard observed the fall and went to the cell door to look in on the AP but did not take any further action. The AP lay on the cell floor for approximately another two hours before an officer came to release him. The AP was found to be unresponsive, and despite immediate life-saving measures was subsequently declared deceased.

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 and five witness police officers;
- police Computer-Aided Dispatch (“CAD”) and Police Records Information Management Environment (“PRIME”) records;
- audio recordings of police radio transmissions;
- video recordings showing events in public during the slow-speed police pursuit of the AP, and in the RCMP detachment;
- scene examinations and exhibits;
- RCMP policies;
- RCMP cell block documentation;
- BC Emergency Health Services records; and
- autopsy and toxicology reports.

NARRATIVE

Civilian Witness 1

Civilian Witness 1 (“CW1”) told the IIO that on the night of September 30 to October 1, 2022, she was in Williams Lake, riding with the AP on a moped. She said a police vehicle followed the moped into a gas station parking area and tried to “corner” it.

The AP turned the moped around and drove away on a service road. The police vehicle followed, pulling in front of the moped, but the AP again turned the moped around and headed back onto the highway, driving through a red light in the oncoming traffic lanes. He then turned into another parking lot at a Shoppers Drug Mart. At that point, CW1 described the police officer pointing a gun at her and the AP, telling them to stop:

He was saying stuff, sticking his gun out the window, but I couldn't really hear him from – 'cause we were looking the other way 'cause we thought he was going to shoot that gun ... When we were turning he had his hand out the window and yelling, but facing that gun towards us.

The AP again drove away, steering the moped onto pedestrian pathways at the Williams Lake Stampede Grounds.

CW1 said that, a few minutes later, when they were back on the highway, another officer blocked the moped by slowing in front of it, while a second arrived from behind. As the AP tried to turn again to escape,

...that one cop that stopped and he ran up and when we're turning to go back the other way he yanked at [the AP] off and then we crashed ... They tackled [the AP] when they yanked him off the bike and then it fell over with me and then they cuffed [the AP]...

CW1 described the AP being handcuffed while face-down on the ground. She said that she did not believe there was any fighting, and that the AP did not resist arrest. CW1 then described the AP sitting on the curb by himself while handcuffed and later standing in front of a police car unassisted. She did not believe the AP was injured and said that he had earlier consumed some alcohol but did not appear intoxicated. He was placed in a police vehicle for transport to the RCMP detachment and she was taken to a different vehicle.

Arresting officers

The first officer to try to stop the AP was Witness Officer 1 (“WO1”). He told IIO investigators that he was aware at the time of the incident that the AP was prohibited from operating a motor vehicle, and that he had a history of fleeing from police. WO1 said that when he initially tried to pull the AP over at the gas station, there was no verbal interaction before the AP simply drove off. Subsequently, he said, when he approached the moped on the street, he got close enough to open the window and shout at the AP to stop. He said that he did not draw his gun at any time during the incident.

Witness Officer 2 (“WO2”) saw the AP on the moped and radioed that the AP “did a u-ball” immediately after the officer drove past him. At about this time, an officer came on the radio to say that the AP appeared to be travelling at only about 40 km/h.

Then WO1 radioed to Witness Officer 3 (“WO3”), telling him that the moped was behind WO3:

...he is right behind you, man. If you can box him in, if you can slow him up if he comes straight up here, then we are good to go.

WO1 said that just before the arrest of the AP, the AP dropped a backpack onto the street, and WO1 stopped to pick it up. He described then seeing WO3 out on foot and the moped fall to the ground and all three individuals (the AP, CW1 and WO3) fall with it. He said that he was about fifty metres away, and started running to assist WO3, but WO3 assured him, “We’re good.” WO1 said there was no struggle and no difficulty in handcuffing the AP. He said there were no visible injuries to the AP. WO1 drove CW1 home from the scene.

When WO3 gave his account to IIO investigators, he recalled running after the moped and grabbing the AP from behind. He said he fell to the ground on top of the AP and CW1 (who was seated in front of the AP on the moped). WO3 said that the AP appeared to be unharmed, walking normally after the arrest and with no complaint of injury. For his part, WO3 said he suffered a minor injury to his knee from the fall.

Witness Officer 4 (“WO4”) arrived at the scene and later told the IIO that he remembered everyone appearing calm and uninjured. He transported the AP to cells, searched him, attempted to contact his legal counsel, and lodged him in a cell.

Video evidence of the pursuit

Security camera video of WO1's police vehicle when it "cornered" the moped momentarily at the gas station shows reflections on the driver's window, indicating that the window was closed. WO1 did not turn on his vehicle's lights or sirens at this point. Similarly, Shoppers Drug Mart security video shows that at the time when WO1 was said by CW1 to have pointed a gun through the window, the window was closed. WO1's hands can be seen intermittently, from different angles, either on the steering wheel or operating his radio. This objective evidence does not substantiate CW1's allegation, which would otherwise raise serious concerns about a potential firearms offence on WO1's part. As mentioned above, the only point at which WO1 described opening the window to shout at the AP was when he was trying to pull the moped over as he drove along the street.

Traffic camera video was also examined, and does not disclose any driving offence by officers as they manoeuvred to stop and arrest the AP. At one point, WO1 can be seen to drive through a red light, but he did so appropriately and in accordance with the *Emergency Vehicle Driving Regulation*, with his emergency lights activated.

The moments before the AP's arrest also appear on CCTV video from commercial premises. WO3 can be seen braking in front of the moped as WO1 drives up from behind. As WO3 turns on his vehicle's emergency lights, the moped appears to attempt to drive past on the left side. The physical arrest is out of view of the camera.

None of the involved police vehicles was equipped with a Watchguard dash camera, nor was any officer equipped with a body-worn camera.

Decision to detain the AP in cells

At the time of the AP's arrest, he was subject to two separate orders prohibiting him from operating a motor vehicle, and he was already facing two outstanding charges of driving while prohibited. He had never held a B.C. driver's licence. WO1 arrested him on a new charge of driving while prohibited, and for driving an "unplated" vehicle. Police had found bear spray in the AP's backpack, and WO3 told the IIO that the arresting officers also intended to charge the AP with possession of a weapon. WO3 said that he and WO1 made the decision to take the AP to cells in order to review his record. Officers could then decide whether the AP should be taken before a judge to be placed on further conditions.

The prisoner log filled out and initialled by WO4 stated that the AP was to be held "for investigation." The evidence indicates that once the arresting officers decided the AP was

to be charged, they needed to complete the paperwork involved and review the AP's offending history to determine if he should be released on conditions.

The log noted that the AP was reported as having consumed alcohol that evening, and that he showed signs of intoxication. WO4 told the IIO that the AP was placed in a normal cell rather than the "drunk tank" as he was not seriously intoxicated. WO3 told IIO investigators that the AP was consistently polite and cooperative with them. WO3 said he had dealt with the AP numerous times and described him as "pretty easy to deal with, a very happy-go-lucky kind of kid."

The civilian jail guard on duty that night, Civilian Witness 2 ("CW2"), said that the AP was able to converse lucidly and was not stumbling. CW2 did not recall any injury to him, or any medical issue, and said that, once in the cell, the AP immediately fell asleep.

In detachment video recordings, the AP appears uninjured and able to move around and walk unassisted without difficulty as he exits the police vehicle, is booked in and placed in the cell. Although the video lacks some clarity, there does not appear to be any injury to AP's head or face, which has significance for analysis of the later events.

The AP's time in cells

The Williams Lake RCMP detachment was short-staffed that night. The watch commander was not on shift, and the acting watch commander was sick and had gone home. WO2 stepped in and took over as acting watch commander. By midnight, only two Williams Lake RCMP members were on duty at the detachment, so WO1 and WO3, who were normally attached to another unit, agreed to stay on overtime to assist. PRIME records show that in the period between 1:00 a.m. and 2:00 a.m., WO1 and WO3 worked on their reports related to the AP's arrest and new charges. At about 2:15 a.m., WO2 and WO4 left the detachment to respond to a domestic disturbance call at a location more than an hour's drive from Williams Lake, leaving WO1 and WO3 at the detachment. At about 2:20 a.m., WO1 and WO3 left the detachment to respond to a call, leaving no police officers in the RCMP detachment, and only CW2 available to monitor prisoners.

At 2:57 a.m., CW2 radioed for WO3 to come to cells to release "two prisoners." Records show that at 3:13 a.m., WO1 and WO3 were still away, dealing with another call, and at 3:56 a.m., CW2 radioed again to remind them about the prisoners. WO3 replied that the officers would be back soon, but at 4:05 a.m. they were needed in response to another call. Records show they cleared from that call at 4:19 a.m., enabling them to return to the detachment.

While these events were unfolding, the AP's time in the cell was being continuously recorded by CCTV video. IIO investigators compiled the following observations from close inspection of those video recordings.

- 00:29:00 a.m.: the AP enters the cell under his own power and lies down on his back on a mattress on the bench, appearing to go to sleep, occasionally changing position, for example from back to side, and moving his arms and legs.
- 02:56:57 a.m.: the AP begins a series of physical motions, including movement of his head and limbs.
- 02:57:05 a.m.: the AP is seen to fall off the bench onto the floor, appearing to land on his forehead without using his hands to break his fall. He continues to move on the floor and rolls onto his side, facing away from the door and the camera.
- 02:57:11 a.m.: CW2, who was sitting in front of the CCTV monitors at the guard station when the AP fell, stands up, looking at the monitors.
- 02:57:24 to 02:58:09 a.m.: CW2 walks to the AP's cell and looks in through the observation window. The length of time she spends looking in is significantly longer than on previous occasions that night when she had conducted physical checks. It is not possible to determine from the video whether any conversation takes place, due to the relatively poor video quality, no audio track, and the fact that the AP is facing away from the camera. The AP is seen to make movements during the time CW2 is at the door.
- 02:59:00 a.m.: the AP remains lying on the floor and is not seen to move again from this time until he is subsequently discovered unresponsive by WO1.
- 03:00:46 a.m.: CW2 conducts another brief physical check on the AP from outside the cell door.
- 03:01:09 a.m.: CW2 appears to make a radio call. It is likely this is the call she made to WO3, asking for him to come to cells to release two prisoners, the difference in time stamps (the radio call was logged at approximately 02:58) being due to a slight difference between the clocks in the radio and video systems. CW2 makes no mention of the AP in that call.

RCMP records indicate that five other individuals were detained at the detachment during part or all of the time the AP was in cells. Despite extensive efforts, IIO investigators were only able to speak with two of those potential witnesses. Both stated that they did not see or hear anything unusual or concerning during their stay in cells.

Interviewed by the IIO, CW2 acknowledged having seen the AP fall. She said she went to the cell and observed the AP through the window. She said she asked him if he was okay, and he said he was. She said the AP sat up and looked at her and then lay back down with his head on his arm. She said she again asked him if he was okay, and he said he was “good.” She said he was moving and had assured her he was okay, so she was no longer worried about him. She considered he was just sleeping, and it was not unusual for prisoners to spend their time in cells sleeping.

CW2 told IIO investigators that she “did tell the watch commander when he came through” that the AP had fallen from the bunk. No officer was present in cells from before the AP fell until prisoners were being released close to the time the AP was located unresponsive. CW2 did not notify any officers over the radio or phone that the AP had fallen, and as such, CW2 did not notify any officer that the AP had fallen until after he was found to be in medical distress. WO2 did not have memory of CW2 telling him the AP had fallen. Witness Officer 5 (“WO5”), the detachment commander, said he spoke with CW2 after the AP was found in medical distress and CW2 told him the AP “had rolled off the bed ... approximately one hour to 90 minutes previous . . . and that he appeared okay on the floor.”

RCMP National Policy requires physical checks (that is, physically at the cell door, rather than remotely via a television monitor) frequently and at “irregular intervals” no more than fifteen minutes apart. During the AP’s time in the cell, CW2 conducted physical checks at the following approximate times: 12:41, 1:01, 2:57, 3:00, 3:28, 4:18 and 4:41 a.m. CW2 told IIO investigators that although she knew physical checks on prisoners had to be conducted at least every fifteen minutes, she had done fewer physical checks than usual on the night of the AP’s death in cells because her knee was hurting. The prisoner log shows CW2 conducted checks on the AP approximately every fifteen minutes using a combination of physical and CCTV checks.

At about 4:48 a.m., WO1 entered the AP’s cell to release him on conditions. He found the AP unresponsive and immediately called for paramedics to attend urgently. WO1 told the IIO that when he came to the cells area, CW2 told him that she had checked on the AP and he was fine, so he dealt with the release of two other prisoners first, as he believed the AP was sleeping. He then discovered the AP clearly in medical distress, and he and WO2 attempted emergency first aid, including administering Narcan. WO2 told the IIO that the AP still felt warm while WO2 was administering CPR to him.

At approximately 5:00 a.m., EHS paramedics arrived and took over the AP’s care. He was subsequently declared deceased.

Postmortem report

The postmortem report did not identify a cause of death, and provides as follows:

This postmortem examination revealed cutaneous injuries of the face only. No injuries of the musculoskeletal system, major blood vessels, or internal organs were identified. No disease processes were identified. Postmortem toxicology identified a blood alcohol concentration of 0.059% and marijuana metabolites only. No substances associated with addiction or used for non-medical purposes, prescription or over-the-counter medications.

Conclusion:

No anatomic or toxicological cause of death was identified on postmortem examination. A review of the scene and incident investigation identified a possible medical event occurring in the decedent hours prior to his death; however, given the limited autopsy and ancillary test results, the medical event in question can only be speculated, including an arrhythmia, a seizure, or sudden dyspnea.

Given the decedent's age and limited autopsy findings, a channelopathy is possible. A channelopathy is a rare condition where, at the molecular level, ion channels do not form properly, inhibiting proper ion movement/electrical current and subsequently resulting in an arrhythmia. Channelopathies have a genetic component and thus might have been inherited.

No estimate of time of death was provided. Regarding evidence of injury, the Postmortem Exam Report stated:

Externally, on the right anterior scalp (on the hairline) is a combined pink-purple abrasion and contusion measuring 3.8 x 2.1 centimeters. On the right forehead is a red-brown abrasion measuring 3.5 x 1.4 centimeters. Over the bridge of the nose is a red-brown abrasion measuring 1.7 x 0.3 centimeters. Above the right half of the upper lip is a red-brown abrasion measuring 1.6 x 1.4 centimeters. Internally, no injuries of the internal organs, major blood vessels, or musculoskeletal system was identified.

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 the 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 intended to enhance public confidence in the police and in the justice system overall 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 a criminal 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 IIO does not have the power to find civil liability, to order payment for damages or restitution, or to address any allegation of non-criminal police misconduct.

Further, while the IIO's investigative jurisdiction encompasses any incident involving death or serious harm with a potential connection to police action, the CCD's authority to refer matters to Crown counsel was, at the time of this incident, limited to charges against "officers" as defined in the *Police Act*. In other words, the CCD could not refer charges against individuals, like civilian jail guards, who were not captured by the definition of "officer." As of September 1, 2025, an amendment to the *Police Act* has brought both on- and off-duty detention (jail) guards under the jurisdiction of the IIO with respect to any future incident where a detention guard may have caused serious harm or death.

Actions of the civilian jail guard – Civilian Witness (CW) 2

In this case, CW2 did not meet the standard of care that is required by RCMP policies of a civilian jail guard. Those responsibilities include monitoring detainees in cells and taking immediate steps to summon medical aid whenever it appears it may be necessary. Guards are not permitted by RCMP policy to enter cells except in the company of an officer, so the guard's duty, whenever there is a concern about a prisoner's physical welfare, is to inform officers and have them come to cells to assist.

As set out above, CW2 failed to adhere to RCMP policy with respect to the frequency of physical cell checks, even after she had personally observed the AP's fall onto the concrete floor. CCTV evidence shows no physical checks of the AP were conducted by CW2 between 1:01 and 2:27 a.m., and again no physical checks occurred between 3:01

and 4:18 a.m. The evidence that CW2 observed the AP fall and immediately conducted a physical check on the AP shows that she was aware of a cause for concern at that point. Her statement that the AP sat up to respond to her when she came to the cell door is not supported by the video evidence. The AP does momentarily lie on his back where it is possible CW2 could see the AP's face. The AP then rolls over to his left side, facing away from the door and the camera. It cannot be determined by the video evidence whether a conversation took place between CW2 and the AP but does not rule out that a conversation took place, as stated by CW2. The AP is still moving his head and body when CW2 returns to the guard room. The fact that CW2 went back to the cell after only three minutes and then called for WO3 to come to cells without mentioning the AP may indicate that she was aware she should do something.

Of significant concern is that CW2 did not notice, during physical and CCTV checks, that the AP did not appear to move from approximately 2:59 a.m. until 4:48 a.m., when WO1 entered the AP's cell to release him and discovered the AP in medical distress. Previous detection of the AP's medical condition may have provided opportunity for earlier medical intervention.

CW2 noted that there are times when a physical check every fifteen minutes is not practical, for example, if it was "super busy" or they are dealing with multiple prisoners for transfer to another prison. CW2 stated that she performed fewer physical checks that night due to her knee giving her pain. CW2 mentioned she was always able to look at the cameras. CCTV evidence shows that CW2 did spend most of the evening in front of the bank of CCTV monitors and was not absent from her post for any extended periods of time. As noted, it is likely regular checks were made on the AP approximately every fifteen minutes, however, many of these checks were CCTV checks rather than physical checks. RCMP policy notes that the use of CCTV "may augment but not replace physical checks."

Further, in the prisoner logbook, CW2 initialed all checks—whether physical checks or CCTV checks—in the physical check column. CW2 stated it was her common long-term practice to initial all checks in this column, that this was never addressed by a supervisor, and that "there was no decision that night to it that way, it's just that was how it was always sort of done."

Actions of involved officers

With respect to the actions of the involved officers, the officers who were initially involved with stopping and arresting the AP were acting in lawful execution of their duty. The AP was a repeat driving offender and there was authority for police to arrest him, and to use a reasonably necessary level of force in doing so. WO3's act in grabbing the AP and

pulling him and the moped to the ground was not excessive, given the AP's repeated evasion of the pursuing officers. There is no evidence of any unjustified force involved in the arrest at any point, and no evidence of any resulting injury to the AP.

The decision to take the AP into custody can be questioned, given the available alternative of releasing him immediately on paper "process." It appears, however, that the concerns about the AP's continuing offending had reached the point where police felt they should consider whether more significant conditions were needed. In the circumstances, it was not inappropriate to hold him in cells while paperwork was completed.

Once the decision to hold the AP in cells was made, officers had a responsibility to safeguard him. His detention in custody placed him within the definition of a person owed a specific legal duty under section 215 of the *Criminal Code*. The duty owed to detainees by their custodians is the duty to provide "necessaries of life," which include medical care if required. It is an offence to fail in that duty, without "lawful excuse," if the failure endangers the life of the detainee.

Officers, particularly the watch commander, are ultimately responsible for the welfare of prisoners. While RCMP policy places officers in a position where they must rely heavily on civilian jail guards for minute-by-minute monitoring, this reliance does not absolve officers of their duty to ensure adequate supervision of those guards and their role in safeguarding prisoners. RCMP policy directs the RCMP supervisor to "ensure that you check the cell block during your shift and sign the Prisoner Log Record Book each time." In this case, the log shows that a check was made of the cell area by a supervisor around 10:39 p.m.

Facial injuries and cause of death

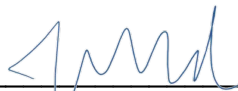
As noted earlier, while the autopsy report details injuries to the AP's face, these are not visible on the video recordings that show the AP as he was being booked into cells. It is reasonable to conclude that the injuries resulted from the AP's fall, face first, from the bench onto the concrete cell floor, and were not caused by officers during his arrest. Further, the injuries to the AP's face were considered "cutaneous," indicating that they did not contribute to his death. The medical evidence, unfortunately, does not provide insight into the cause of the AP's death or assist in determining whether earlier provision of treatment might have changed the outcome.

Conclusion

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 detainees 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 prisoners by jail staff, as well as supervising officers.

In this case, CW2 did not meet the standard of care expected of her. Additionally, the supervision of CW2 on the night of the incident was inadequate, and it is reasonable to conclude that this was due, at least in part, to the detachment being understaffed. Additional concerns about inadequate supervision arise from the apparent practice at the detachment (mentioned above) of condoning staff logging remote video checks of cells as in-person physical checks. In this case, any evidence of lack of supervision of the jail guards does not support a determination that there are reasonable grounds to believe any officer may have committed an offence, although it highlights the critical importance of ensuring that cell block policies, and consequently the way vulnerable detainees receive care, are followed.

The AP was one such vulnerable detainee, and his death while in cells was tragic; however, I do not consider there to be 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.



Jessica Berglund
Chief Civilian Director

October 9, 2025
Date of Release