INDEPENDENT
Investigations Office of BC

IN THE MATTER OF THE DEATH OF A MALE AND OF THE ASSOCIATED ACTIONS OF A MEMBER OF THE RCMP IN KELOWNA, BRITISH COLUMBIA ON JANUARY 10, 2024

DECISION OF THE CHIEF CIVILIAN DIRECTOR OF THE INDEPENDENT INVESTIGATIONS OFFICE

Chief Civilian Director:	Ronald J. MacDonald, KC
IIO File Number:	2024-023
Date of Release:	April 18, 2024

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INTRODUCTION

On January 9, 2024, Civilian Witness 1 ('CW1'), an acquaintance of the Affected Person in this case ('AP') spoke with him by phone from out of province. She was worried by AP's apparent very poor health, and told him she would call back the next day. On January 10, when she called back, there was no answer, so she called police to ask for a well-being check. The Subject Officer ('SO') was dispatched to AP's apartment building, but was not able to find AP's buzzer number on the front door directory so he left, telling CW1 to find someone else to check on AP. The apartment manager found AP deceased in his apartment later that morning.

On January 24, 2024, CW1 lodged a complaint with the RCMP. On February 2, 2024, the RCMP notified the Independent Investigations Office ('IIO') about AP's death and the potential connection with the action or inaction of an officer. The IIO immediately commenced an investigation.

The narrative that follows is based on evidence collected and analyzed during the investigation, including the following:

- police Computer-Aided Dispatch ('CAD') and Police Records Information Management Environment ('PRIME') records;
- Closed-Circuit Television ('CCTV') video evidence from AP's apartment building;
- BC Coroner's Service information; and
- RCMP dispatch policy.

NARRATIVE

SO was initially dispatched to check on AP at 10:02 a.m. on January 10, 2024. Dispatch told him that CW1 had reported that AP was "extremely sick with laboured breathing". He was also told that AP had no family or contacts in Kelowna, and that he had not answered the phone that morning. CAD entries indicate that SO was on scene at 10:40:16 a.m., and cleared the scene at 10:42:42, less than two and a half minutes later.

SO's General Occurrence report in PRIME indicates that tenant names are not listed on the directory at the front door of the apartment building "and the apartment numbers on the buzzer are coded". According to the report, SO "updated" CW1 and concluded the file.

A video recording from the building lobby shows SO appearing outside the front door, examining the building directory and then leaving. He is there for approximately two minutes.

At 11:48:53 a.m. the same morning, SO was again dispatched to AP's home. This time, the call was to assist paramedics with a sudden death. AP had been found deceased by a staff member. A PRIME report with respect to that second police attendance indicated that SO briefed a supervisor on scene, but there is no indication that SO told the supervisor that he had been at the residence about an hour earlier, or that he had failed on that occasion to conduct a requested wellness check.

The report by the BC Coroners Service indicates that the death was from natural causes, and was determined to have occurred some time on January 9, 2024.

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 a potential negligence offence, 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 the possible offence of 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. This is a significant

test, as Canadian criminal law does not sanction "ordinary" negligent errors, just very significant ones that therefore justify a criminal sanction.

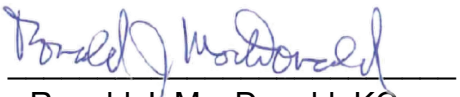
SO's failure in this case to properly comply with his sworn duty to protect life was significant and came at least very close to and quite likely crossed the criminal negligence threshold. SO had information that AP was seriously ill and was no longer answering his phone. After the RCMP got a call to check on a very sick person, SO almost immediately abandoned his investigation after being stopped by the building's front door. There were other options he could have pursued but he failed to take any, other than to call the complainant back to tell her to get someone else to do the job he had been tasked to do.

In these circumstances, to meet his duty to protect life, the evidence should show that SO made serious efforts to check on AP to determine his physical state. That should include more than just walking away upon being unable to determine how to access the building. For example, he could have attempted to rouse other occupants of the building, or contact the superintendent or property owner. Indeed, a forced entry in these circumstances would quite likely have been appropriate. In this case, based on the evidence available to this investigation, SO did very little. His actions showed a poor regard for the potential that AP was in a grave physical state.

However, the objective evidence here indicates that the failure of SO to gain entry and conduct a check on the deceased did not make any difference to the unfortunate outcome. The evidence would strongly suggest that AP was already deceased when SO initially attended. That being so, it cannot be said that the evidence establishes that SO committed the offence of criminal negligence causing death, given that his inaction cannot be said to have caused AP's death when AP was very likely already dead.

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.

SO's inactions may well constitute a breach of RCMP policy and practice, which is a matter for their Professional Standards branch to address.



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