



**IN THE MATTER OF THE DEATH OF A WOMAN
AND AN ASSOCIATED INVESTIGATION BY MEMBERS OF THE RCMP
IN BURNABY, BRITISH COLUMBIA
ON MARCH 18, 2026**

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

Chief Civilian Director: Jessica Berglund

IIO File Number: 2026-064

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INTRODUCTION

On the afternoon of March 18, 2026, a Burnaby RCMP member went to the home of the Affected Person (“AP”) to conduct a wellness check. The officer found the AP unresponsive on the bathroom floor and concluded from his observations that she was deceased. A second officer then attended and reached the same conclusion, so a coroner was summoned. When the coroner examined the AP, however, she noted signs of life. Medical assistance was called and the AP was transported to hospital. Because emergency personnel had found a “Do Not Resuscitate” form at the AP’s home, medical staff kept the AP stable but did not provide any further medical intervention. The AP was declared deceased on the morning of March 19, 2026.

Because of the connection between the AP’s death and the actions of police, 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 (including five first responders) and three witness police officers;
- police Computer-Aided Dispatch (“CAD”) and Police Records Information Management Environment (“PRIME”) records;
- audio recordings of a 911 call and police radio transmissions;
- key fob history data from the AP’s residential building;
- BC Emergency Health Services and Burnaby Fire Department records;
- RCMP policies; and
- autopsy report.

The IIO does not require officers whose actions are the subject of an investigation to provide evidence. In this case, neither of the two subject officers gave a statement to the IIO, but investigators were able to access written reports they had filed before the investigation began.

NARRATIVE

At 2:15 p.m. on March 18, 2026, Civilian Witness 1 ("CW1") called 911 to request a wellness check at the residence of the Affected Person ("AP"). CW1 was a social worker, and reported that the AP, an elderly woman who lived alone, had missed a medical appointment several days earlier. He said that, concerned for her welfare, he had been attempting unsuccessfully to contact her by phone and by going to her home.

At 2:42 p.m. that day, Subject Officer 1 ("SO1") went to the AP's apartment building and entered the AP's unit with the assistance of the building manager. He found the AP lying unresponsive on the bathroom floor, and from his observations of her, concluded that she was deceased. In his written PRIME statement, SO1 stated that he:

...called out to [the AP] from the hallway, then stepped into the bathroom to assess her for signs of life. [SO1] did not observe any signs of breathing nor pulse from [the AP] and did not observe any movement or noise from [the AP]. He did not attempt to move [the AP] around...

SO1 wrote that he concluded the AP was "obviously deceased." Following sudden death protocols, he radioed for a more senior officer and a coroner to attend.

Subject Officer 2 ("SO2") responded to SO1's call, arriving at 2:59 p.m. In his PRIME report, SO2 wrote that he believed the AP was deceased from a heart attack and did not find the death suspicious. In the report, SO2 did not mention taking any steps to examine the AP or check for breathing or a pulse. He noted that SO1 had taken pictures of the scene and had contacted the AP's family members. SO2 then returned to the detachment while SO1 remained at the scene. SO2 subsequently reported to Witness Officer 1 ("WO1"), a supervisor, that neither of the subject officers had touched the AP or checked for a pulse.

At 5:20 p.m., a coroner arrived. She examined the AP and found her to be breathing, with a weak pulse. SO1 immediately radioed for an ambulance to attend "code three" (with emergency lights and siren activated). Firefighters and paramedics responded and provided aid to the AP, moving her to the living room and attempting to stabilize her before transporting her to the hospital. While this was continuing, the first responders found an envelope containing a "DNR order," a direction that the AP not be resuscitated.

As the AP was being carried from the apartment on a stretcher, Witness Officer 2 ("WO2"), also a supervisor, arrived at the scene. WO2 told the IIO that he asked SO1 what had happened. He said SO1 told him that he had looked at the AP and determined she was deceased. He said SO1 told him he had walked around the apartment to check for any sign of a break-in or foul play but had refrained from touching the AP in accordance with

his training. WO2 said he told SO1 that it was his duty in those circumstances to check for a pulse and that he “needed to do a better job.”

Interviewed by the IIO, Civilian Witness 2 (“CW2”), a fire department supervisor, described the observations he had made of the AP upon arrival at the apartment, and stated that despite the coroner’s advice that she had detected a pulse, he believed the AP was deceased. He said that two of his firefighters also told him they thought there was a faint pulse and breathing, but it was hard to detect. CW2 said he decided not to move the AP and to wait for paramedics to arrive.

Civilian Witness 3 (“CW3”), one of the firefighters, told investigators that he had found a faint pulse, but had to listen very closely to be able to detect breathing. He said it would be understandable, based on the AP’s condition, that a person would believe she was deceased. Civilian Witness 4 (“CW4”), a paramedic, also told the IIO that the AP had the appearance of a deceased person, that it was challenging to find a pulse and that her breathing was not readily apparent.

Evidence gathered by IIO investigators indicated that the AP had not been outside her home for a significant period before police attendance on March 18, 2026:

- Key fob history from the AP’s apartment complex indicating a regular pattern of movement by the AP through February showed no movement after March 3.
- The AP’s last medical appointment was in mid-February, and she had missed a scheduled appointment during the week of March 9.
- CW1 told the IIO that because of this missed appointment, he had tried several times to contact her by phone and by personally going to her residence, without getting a response.

The AP was declared deceased at the hospital at 10:27 a.m. the following day, March 19, 2026. On March 20, RCMP received a complaint about the matter from the AP’s family members and notified the IIO, after telling the family that the RCMP had initiated a review of the circumstances surrounding the police response.

The AP’s post-mortem report stated the cause of death as “hypertensive and atherosclerotic cardiovascular disease” with “no other significant conditions contributing to the death.” Some aspects of the AP’s physical condition indicated that she had been lying in the same position on the floor for a considerable time, possibly several days.

IIO investigators obtained copies of several RCMP policies with potential relevance to this case:

- National policy regarding wellness checks (attendance by police to verify the condition and/or safety of a person) states that an officer should “consider engaging local support resources,” which could include medical personnel, but does not make this mandatory for all such calls.
- With respect to calls where it is discovered that a person appears to have died from natural causes, national RCMP policy instructs the officer to notify a supervisor and request assistance from a coroner or medical examiner for body removal and examination. RCMP provincial policy further specifies that the officer “must not in any way, without prior authorization from the coroner, move, alter or destroy the body or its immediate environment.” That provincial RCMP policy reflects a provision in the B.C. *Coroners Act* that makes it an offence to move a body without authorization from a coroner.

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 goal 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 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.

In a case such as this one, involving a potential negligence offence, the IIO investigators collect evidence about whether officers met the relevant standard of care.

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 those sufficiently serious to justify a criminal sanction.

The evidence indicates that if either of the subject officers had carefully checked the AP for signs of life, they would likely have discovered that she was not deceased, and medical help for her would have been called sooner. The evidence also shows, however, that experienced first responders such as CW2 and CW3 were surprised that the AP was alive, based on their observations. It is also apparent that even when checked, both the AP's pulse and her breathing were difficult to detect.

In summary, it was reasonable for the attending officers to conclude that they had been called to a scene where a person had died from natural causes, and that RCMP policy to not move the body and call a coroner applied. The evidence does not establish that either of the subject officers was criminally negligent in their response.

Accordingly, 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.



Jessica Berglund
Chief Civilian Director

October 22, 2026

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