SiRT | SERIOUS INCIDENT RESPONSE TEAM

Summary of Investigation

SiRT File # 2013-019

Referral from

RCMP - Queens County

July 9, 2013

Ronald J. MacDonald, QC
Director
March 7, 2014

Facts:

On July 8, 2013, at approximately 11 p.m., a 40 year old male (AP) was found by civilians lying on the River Head Road in Queens County. 911 was called to report an intoxicated male. Both Emergency Health Services (EHS) and the RCMP responded. AP was arrested for being intoxicated in public and transported to the RCMP detachment in Liverpool. He was lodged in cells by Officers 1 and 2 just before 1 a.m. At 1:30 a.m., the civilian jail guard (Officer 3) became concerned about AP's health and called for assistance from the Officers 1 and 2 who were out on a call. When they arrived at 1:59 a.m., AP was not breathing and CPR was commenced. EHS arrived and AP was transported to hospital. He was pronounced deceased at 2:41 a.m.

In accordance with the requirements of the *Police Act*, shortly after AP died, the RCMP referred the matter to SiRT, which immediately assumed responsibility for the investigation. The investigation was completed on February 3, 2014. Conclusion of the file was dependent on receipt of the Medical Examiner's (ME) report, which was required for subsequent consultation with the Public Prosecution Service. That report was received on January 17, 2014.

During the investigation, SiRT interviewed 16 civilian witnesses and two witness police officers. SiRT obtained and reviewed relevant cell block video, RCMP files and policies, scene and cell block photos, as well as cell phone video of AP in the back of the police vehicle after arrival at the detachment. SiRT also acquired 911 and police radio transmissions, the prisoner log and report, and relevant video from the local Nova Scotia Liquor Commission store and a local garage. In addition, copies of text messages from AP's phone for the several days prior to July 8 were obtained.

Officers 1 and 2 were both subject officers in the investigation. In addition, the Serious Incident Response Team Regulations made under the *Police Act* give SiRT jurisdiction over civilian jail guards when they are on duty. The guard in this case, Officer 3, was also designated a subject officer. Under the same regulations, no subject officer is required to give a statement to SiRT, nor are they required to make available their notes or any other reports. Nevertheless, in this case all 3 subject officers provided statements and their reports to SiRT.

The investigation showed that AP suffered from depression, and was suffering from numerous personal issues in his life. He had diabetes, was still affected by his mother's death four years earlier, was battling alcoholism, and had lost his job in the fisheries due to his drinking. His relationships with his ex-wife and girlfriend were poor. He had other family issues as well. He had one outstanding minor criminal matter.

On July 8, AP made two trips to the Nova Scotia Liquor Commission to purchase vodka. During the afternoon he was texting his girlfriend. The content of the texts are best described as hostile. He also texted derogatory comments to his ex-wife.

At 6:58 p.m. AP texted his girlfriend and stated no one will see him after that evening and to give him a few hours before anyone looked for him. After his death, an unsent text was found on his phone. In it AP was saying goodbye to people he was close to.

At approximately 8 p.m. AP was seen by his sister turning his car around in her driveway. This is not far from River Head Road. A local resident, driving on the River Head Road, saw AP lying by some lobster traps at 11 p.m., approximately 350 metres from where his car was parked. He was on a section of road leading to a dead end where one residence is located. The last time someone drove by where he was found was shortly after 8 p.m. The person who found him sought help from other residents on the road, who contacted 911. AP's sister was also contacted and arrived after the police.

Officer 1 was dispatched to the scene along with EHS. Officer 1 arrived first, at 11:37 p.m., and placed AP under arrest for public intoxication. EHS paramedics assessed AP, who had to be helped to his feet and was not totally conscious. They noted he was only responsive to "painful stimuli." The paramedics found no medical reason for AP to be transported to the hospital, and Officer 1 concluded AP could be incarcerated for the evening until he sobered up. Officer 1 needed the assistance of the local residents to place AP in the rear of his police vehicle, which occurred just prior to midnight. Officer 2 arrived at this point. After waiting for the tow company to arrive, both officers left and met at the Queens County Detachment cells just after 12:30 a.m., July 9.

AP was not conscious while being transported to the cells, although he was snoring. Once at the Detachment, Officer 3 was called in to work. Officers 1 and 2 attempted to rouse AP, using a variety of efforts, including pouring water on his face. AP did not gain consciousness. AP was a large man, weighing more than 225 pounds. In order to get him into the cell, the officers pulled him from the police vehicle and laid him on a police emergency blanket. They then pulled him along the floor to the cell. Once there he was placed on a mattress on the floor in the recovery position. At no time did he regain consciousness.

RCMP policy states that if a person is unconscious or not fully conscious, or there is a marked change in consciousness, or if they may be suffering from alcohol or drug poisoning, immediate medical assistance should be sought. They should not be placed in a cell, unless a medical practitioner has declared the person fit for incarceration. In some cases this may include a paramedic.

RCMP policy also requires officers to assess prisoner responsiveness, and if they do not wake or respond to stimulus, medical assistance must be obtained. The policy reminds officers that drowsiness may be an indicator of serious injury or illness, and that alcohol could mask head injury or drug overdose.

Officer 3 arrived and took over the responsibility of AP at 1 a.m. Officers 1 and 2 left within 15 minutes to attend to two other calls. Officer 3 checked on AP every 15 minutes starting at 1 a.m., confirmed by video. He heard AP snoring and watched his chest rise and fall. Around 1:30a.m. he noted that AP was no longer snoring. Over the next twenty minutes he observed AP more closely and opened the cell door and entered on several occasions. Officer 3 then contacted Officers 1 and 2 at 1:52 a.m. and requested them to return to the cells. They arrived at 1:59 a.m. and commenced CPR immediately. EHS was called and arrived at 2:04 a.m. and assumed the treatment of AP. AP was removed from the cell at 2:31 a.m. and transported to the hospital where he was pronounced deceased at 2:41 a.m.

The ME's report notes that AP had large levels of morphine and alcohol in his blood. The ME found his death was caused by the self-inflicted overdose of morphine and alcohol.

The ME was not able to say whether if Officers 1 and 2 had transferred AP to the hospital instead of cells it would have made a difference in his survival. In other words, even if he was taken directly to the hospital he still may have died.

The Public Prosecution Service was contacted in the matter and provided advice in relation to relevant criminal law issues.

Relevant Legal Issues:

The main legal issue relates to the duty of care shown by each of Officers 1, 2, and 3 when dealing with AP, a person in custody.

Section 215 of the *Criminal Code* provides that when a person is responsible for someone in custody, they have a duty to ensure that person is provided with the "necessaries of life." "Necessaries of life" includes the obligation to provide food, water, and where relevant, necessary medical care or attention. This can also include a requirement to ensure appropriate checks are made to ensure such person is safe and not in need of medical attention.

In order for a person's behaviour to be serious enough to be captured by this offence, that behaviour must be more than just being neglectful in carrying out one's duties. It must be significant enough to constitute a marked departure from the standard of care expected of a reasonably prudent police officer or guard in the circumstances. Additionally, that failure to provide care must cause the death of AP.

Police agencies in Nova Scotia have developed policies to outline the responsibilities of their police officers and jail guards designed to protect the health and welfare of people in custody. A failure to meet those policies does not automatically mean an offence is committed. Indeed, in most circumstances, to constitute an offence, departure from the policies would have to be significant and substantial.

Conclusions:

AP was going through difficult personal times on July 8, 2013. At some point, he made a decision to ingest morphine and alcohol in an effort to end his life. Consistent with his final text messages, and the unsent text, he chose to go somewhere and die.

AP's unconscious body was found at 11 p.m. He was likely lying at that point for a few hours. Officer 1 was given no reason by EHS not to incarcerate AP. He thought AP was intoxicated by alcohol.

Once back at the detachment, both Officers were unable to rouse AP, who was breathing. They decided to pull him across the floor and into the cell in an unconscious state. While they had the advice of EHS given prior to midnight, AP's condition had now changed. He was no longer responsive to their significant attempts to rouse him, including pouring water on his face and then dragging him. The policies suggest that EHS should have again been called, or AP should have been taken to the hospital, a short distance away. Failure to take these steps would appear to be inconsistent with RCMP policy.

Once in custody, Officer 3 took charge of AP after 1 a.m. He made the required regular checks on AP. When he noticed a change in AP's condition after 1:30 a.m., he made efforts to seek assistance by calling Officers 1 and 2. Officer 3's actions were reasonable in the circumstances.

A failure to follow policy does not mean a criminal offence was committed. Importantly, to be an offence the actions of Officers 1 and 2 must have caused AP's death. In this case, the ME was not able to say earlier medical attention would have made a difference. Thus, it is not possible to say the actions of the Officers caused the death.

In addition, to be an action that justifies criminal sanction, it must be a marked departure from the appropriate care. In this case, while there was a difference in AP's condition between when he was examined by EHS and when he was taken to the detachment, it was arguably not that different. At the roadside, he was difficult to rouse, and had to be helped to stand by Officer 1 and others on scene. He only responded to painful stimuli. Thus while Officers 1 and 2 may have been in error to incarcerate AP while unconscious, any error made does not constitute a marked departure from reasonable care.

The sections of the *Police Act* relevant to SiRT state that the Director of SiRT has the sole authority to determine whether charges should be laid in any matter investigated by SiRT. In this case, I have determined there are no reasonable grounds to consider any charges against Officer 1, Officer 2, or Officer 3.