

SiRT

SERIOUS INCIDENT
RESPONSE TEAM

Summary of Investigation

SiRT File # 2016-024

Referral from Halifax Regional Police

August 22, 2016

Ronald J. MacDonald, QC

Director

March 7, 2017

Facts:

At 10:42 p.m. on August 22, 2016 a 47-year-old male, the Affected Person (AP), was found by members of the Halifax Regional Police (HRP) unconscious in his cell at HRP headquarters. He had attempted to hang himself by tying his sweater around the cell block door. He was taken to the QEII hospital, where it was confirmed he had suffered a serious brain injury from lack of oxygen. Due to his injuries, HRP contacted SiRT at 11:30 p.m. at which time an investigation was commenced into the circumstances of AP's injuries. The investigation was completed on December 7, 2016.

During the investigation statements were taken from six civilian witnesses and reports were received from three witness police officers. In addition, the investigation received and reviewed the following information:

- AP's medical records
- Relevant file materials from HRP
- Relevant HRP Custodial Care of Prisoners & The Use of Video Cameras Policies
- Video of AP's arrival at cells and his entire stay until taken to hospital
- Photographs of the scene
- Video of AP and his interaction with an employee at the Nova Scotia Hospital prior to his arrest

The investigation showed that at approximately 6 p.m. on August 22, 2016, AP went to Pilot's Pub on Atlantic St. in Dartmouth. He was well known by staff and considered a pleasant customer who tipped well. On this evening, he had approximately four beer and some food.

While at the pub AP called his sister in New Brunswick, and also spoke to his mother who was visiting there. They described him as sounding normal, and not intoxicated. He spoke of his current job and seemed pleasant. They were not aware of him having any emotional issues or suicidal thoughts.

AP left the pub before 9 p.m., and at 9 p.m. walked past the Nova Scotia Hospital boiler room. The door to that part of the building was open and is close to the sidewalk. A car was parked between the building and the sidewalk. AP approached the open door and began to berate the employee who owned the car, suggesting he should not park there. This interaction was captured on video. The employee attempted to explain to AP that he was allowed to park there and in fact paid for the spot. Nevertheless, AP angrily criticised him for six minutes, using a loud voice and vulgar language. While the video had no sound, it shows AP as very agitated for the entire encounter. He then left to find hospital security and complain to them about where the man had parked. AP did not seem to have a reason for his complaints as the car was parked properly, and did not impact AP.

The employee called security, worried AP may return. Security officers met AP shortly after he walked away. Their encounter with AP was similar. He was insistent that the car was illegally parked, and would not listen to what the security officers said as they tried to calm him down. At one

point, he grabbed one of the security officers by the arm. He refused to leave the hospital grounds. As a result, the police were called.

Officer 1, who was nearby, responded. Officer 1 also tried to calm AP down and explain the situation, but AP did not listen and was abusive and aggressive. Officer 1 could smell alcohol on AP's breath and placed him under arrest for being intoxicated in public. AP was verbally abusive on the drive back to cells in Halifax.

On arrival at cells AP was compliant with the Officer and walked on his own into the booking area. While he was not physically aggressive, he was verbally abusive. He was processed and lodged in the "tank", a large cell for prisoners who are not physically aggressive. When AP's shoes were passed to him he immediately threw them back into the hallway outside of the cell.

Officer 2 and Officer 3 were working in the cell area that evening and were responsible for the care of the prisoners.

At no time while dealing with Officer 1 or while being processed did AP make any comments that suggested he was considering an attempt on his life or that he was in a depressed state. His commentary was that of a typical person who was unhappy with having been arrested.

AP had previously been arrested, in October of 2015, also for public intoxication. On that occasion while in cells he made efforts to cover the cell's video camera and apparently hang himself, although the efforts seemed unlikely to be successful, and included trying to put his socks around his neck. On release, mental health personnel spoke to AP. He indicated he was just drunk and had no thoughts of suicide.

No notations were made in police records about these actions of AP in 2015. The officers AP dealt with in August of 2016 had no knowledge of AP's previous actions.

A few minutes after being put in the cell in August of 2016, AP tied his sweater around the outside bars of the cell. He then kneeled with the sweater around his neck in an effort to block blood flow to his head. He re-positioned himself several times over three and a half minutes to obtain the desired effect. Shortly after 10:33 p.m., eight minutes after he was placed in the cell, the video shows him motionless.

The cell has three cameras. Only one gave a good view of his actions. In the office portion of the booking area where Officers 2 and 3 worked there was a TV screen which contained views of all cameras in the prisoner facility. As there are many cameras each live screen was relatively small.

The camera in question also had a somewhat blurry picture, likely caused by damage from a previous prisoner. This impaired the view from the camera somewhat.

Officers working in the booking area have administrative duties to perform during their work. On this evening, Officer 2 and 3 appeared occupied with such duties after AP was put into his cell. They are required by policy to check on the prisoners every 15 minutes, but are not expected to study the video constantly as they need to perform their other work. In this case, a quick glance at the monitor would likely have not clearly demonstrated a problem. Rather, it may have seemed AP was simply sitting against the bars of the cell.

At 10:42, about 17 minutes after AP went into cells, Officers 2 and 3 made their in-person checks on the prisoners. Officer 2 found AP with the sweater around his neck and tied to the bars. He immediately lowered the sweater to release the pressure on AP's neck, and then together with Officer 3 untied the sweater from around AP's neck. They then opened the door, and soon thereafter began CPR. EHS and assistance from other officers was immediately requested. As EHS was nearby that help arrived very quickly. While at first a pulse could not be detected in AP, before he was taken to hospital he had a pulse.

Initially AP's prognosis was very dire. He has now recovered significantly. However, he does suffer from a significant brain injury and will need long term care.

Relevant Legal Issues:

The determining legal issue in this matter concerns the degree of care a guard working in a police lockup must provide to 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 necessities of life. Necessaries of life includes the obligation to provide what is needed to preserve life, which might include food, water, and where relevant, necessary medical care or attention. In this case the question is whether Officers 2 and 3 provided sufficient attention to protect AP from injury in his attempt to take his life.

In order for a guard's behaviour to be serious enough to constitute a criminal offence, that behaviour must be more than just being neglectful in carrying out one's duties. Rather, a guard must have acted in a way that the behaviour is significant enough to constitute a marked departure from the standard of care expected of a reasonably prudent guard in the circumstances. Additionally, that failure to provide care must either endanger the life of the person, or cause them permanent injury.

Police agencies in Nova Scotia have developed policies to outline the responsibilities of their 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's behaviour seems to have been out of character. He had not consumed a great deal of alcohol, yet his behaviour at the Nova Scotia Hospital is hard to explain. Video of him at cells show him walking without any balance issues.

While he continued to be verbally abusive at cells, he was otherwise compliant with police and at no time gave any indication that he was considering taking his own life. Thus, AP appeared to be a relatively ordinary admission to cells. In such circumstances his admission did not signal any reason for Officers 2 and 3 to have any concerns about AP.

The fact that AP had made efforts to attempt to take his life the previous year does not play a role in this matter. There was nothing on file to alert any Officer to those facts. While that may or may not be an issue with the overall system of care provided by HRP, it does not impact the individual criminal responsibility of Officers 2 and 3. Simply put, they cannot be expected to be aware of a potential issue they had no knowledge of.

The video of each cell is available for the guards, but is not expected to be the primary way to check on the individuals in custody. Rather, the in-person checks made every 15 minutes provide that information. In addition, in this case the video of this cell would have been a small picture and not completely clear. It is not surprising that Officers 2 and 3 did not notice anything out of the ordinary based on the picture available.

Overall, the actions of Officers 2 and 3 fell well within the expected behaviour of any reasonable guard in these circumstances. After AP was placed in cells, they carried out their expected administrative duties and conducted the required cell check on time, and immediately did what they could to provide AP with emergency aid.

While it is possible to imagine more attention having been provided to AP during his first 17 minutes in the cell, that is not what the law requires. Rather, Officers 2 and 3 are expected to, and did, provide the reasonable care required. In addition, to constitute a criminal offence their behaviour would not only have to be unreasonable, it would have to be a marked departure from the proper standard of care. The actions of Officers 2 and 3 do not come close to that level of neglect.

Therefore, in these circumstances there are no grounds for any charges against Officers 2 or 3.