IIU | INDEPENDENT INVESTIGATION UNIT OF MANITOBA

FINAL REPORT: IIU concludes investigation into death while in RCMP custody in The Pas

On October 6, 2019, the Royal Canadian Mounted Police (RCMP) notified the Independent Investigation Unit (IIU) of a death of a male, later identified as the affected person (AP), following his detention in cells that occurred in the early morning hours of October 6 in The Pas, Manitoba. This notification, provided to IIU (edited for clarity), read in part:

> *"On 2019-10-05 at 6:42 p.m., The Pas RCMP responded to a call of an intoxicated male passed out leaning against the radio station in The Pas. RCMP members attended and arrested AP under the Intoxicated Persons Detention Act (IPDA). He was lodged in The Pas RCMP Cells at 7:08 p.m.*
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> *On 2019-10-06 at approximately 1:30 a.m. after lodging another prisoner, an RCMP member checked on the status of the three prisoners in Cell #7. Cell #7 is referred to as the "drunk tank", which has no beds but does have a toilet. The RCMP member noticed that AP's hands looked dark in color. The RCMP member then kicked the cell door and another prisoner checked AP. AP was not responsive.*
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> *Members entered the cell and moved two prisoners from Cell #7 to another cell…EMS was notified and CPR was initiated along with an AED. EMS attended the detachment and pronounced AP deceased at 1:56 a.m.*
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> *AP is arrested often by The Pas RCMP under the Intoxicated Persons Detention Act. He is homeless and often utilizes The Pas homeless shelter. At the time of the arrest AP was speaking with the members and joking around with them. AP had no visible injuries, was not complaining of health concerns, and did not ask for medical attention at anytime.*
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> *The CCTV of AP's time in cells has been secured and is being reviewed for any further information.*
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> *RCMP Cell #7 has been secured with the body inside. The Medical Examiner's office has been notified. Removal of the deceased pending IIU notification and approval"*

As this matter concerned the death of a person that may have resulted from the actions of a police officer(s), IIU assumed responsibility for this mandatory investigation in accordance with section 66(4) of The Police Services Act (PSA). IIU investigators were assigned to this investigation.

Further, in accordance with section 70(1) of the PSA, the IIU was required to seek the appointment of a civilian monitor, as this matter involved the death of a person. IIU requested a civilian monitor be appointed by the Manitoba Police Commission.

RCMP information, and other information obtained by IIU investigators, included:

- situation report

- occurrence summary
- scene photographs
- cell video
- prisoner report
- notes and reports from witness officers
- prisoner/cell log sheets
- autopsy report
- toxicology report

Due to the dearth of information at the outset of this investigation as to whether any actions by any RCMP officer contributed, to any degree, to the death of AP, it was decided that no subject officer designation would be made at this stage, pending receipt of more facts and evidence. Three designated witness officers (WO1-3) were interviewed by IIU investigators. IIU investigators received notes and reports from three additional RCMP members which were sufficient for this investigation as it was determined that interviews of these officers were not required. IIU investigators interviewed five civilian witnesses (CW1 – 5). IIU investigators met with and interviewed two paramedics (members of The Pas Paramedic Station) (PW1-2). Finally, IIU investigators consulted with the province's Chief Medical Examiner (CME) in review of the autopsy and toxicology reports.

Facts and Circumstances

Scene Examination and Canvass:

On October 6, IIU Investigators attended the RCMP detachment in The Pas, regarding the death of AP while in cells earlier the same date. IIU investigators examined cell #7, referenced as the *"drunk tank"*, the area where AP was placed earlier and found deceased. The cell was found to be secured and vacant. The door was sealed. An AED was on the floor within the cell (property of the RCMP). The guard's desk was noted to be in close proximity of the drunk tank and had numerous television monitors with the various cells displayed, including the interior.

Civilian Witnesses:

CW1 is a part-time guard for the RCMP in The Pas. CW1 was on duty while AP was in custody at the detachment. Her shift ended just before midnight on October 5. CW1 knew AP and believed that he was brought into cells at approximately 9:00 p.m. (as documented in the prisoner log book). CW1 described AP as *"exceptionally intoxicated"* when he was brought in. AP was unable to walk into cells without assistance. CW1 recalled that another male, CW4, was brought into the drunk tank just before AP. There was a third male in the drunk tank, however she could not recall his name. CW1 stated that the guard visually checks the prisoner, either on video monitor or in-person, every 15 minutes and that there is a small window on the cell door that the guard can open to take a better look into the cell if they aren't sure of what they are seeing on the video monitor. CW1 stated that she did not see anything unusual while AP was in the drunk tank. She did not see anything to indicate that he was in any distress. She did not see any interaction or conflict between AP, CW4 or the third male while they were in the cell and noted that they were not cuddled together. CW1 stated that she was relieved by CW2.

CW2 is a part-time guard for the RCMP, The Pas. CW2 was on duty from 11:50 p.m. on October 5 until 2:00 a.m. on October 6. CW2 had relieved CW1 on arrival and noted that there was nothing extraordinary going on in cells. CW2 stated that there were three males in the drunk tank. CW2 was very familiar with AP. CW2 stated that among a guard's duties were to brief with the on-duty guard when they arrive for their shift, note anything special information to share, check on prisoners and check the log book. CW2 stated that she made her rounds and did not note anything out of the ordinary. Prisoners were monitored via the surveillance system and the window on the cell door. CW2 stated that there was no unusual activity during her shift until around 1:25 a.m. At that time, RCMP members lodged another prisoner in cells. An RCMP member, WO1, went on rounds. WO1 knocked on the drunk tank cell door and two prisoners got up. However, the third male, AP, did not rouse and CW2 entered the cell, radioing that assistance was required. Paramedics arrived on scene and CPR was provided to AP. However, within a short time, paramedics declared AP deceased. CW2 stated that her supervisor relieved her from duty early and she went home.

CW3 was walking on the public sidewalk from a local fast food restaurant when he was asked by two unknown males to call the police as a third male with them was extremely drunk. The third male was behind a retail store. CW3 stated that he recognized this male as AP. AP was not talking but was moving against a wall. According to CW3, AP was very intoxicated. CW3 stated that he called the police and left the area.

CW4 was taken into custody by RCMP members on October 5, sometime between 6:00 to 7:00 p.m. He was detained under the IPDA for being drunk in public. While CW4 stated that he had little recollections of the events of that evening, he does recall consuming between 15 to 30 beers prior to his detention. CW3 could not remember if anyone else was in drunk tank when he was lodged. He does not know AP.

CW5 had been taken into custody under the IPDA by RCMP members on October 5. CW5 believed that he was detained near midnight. When he was lodged in the drunk tank, CW5 thought there was already another male sleeping in that cell. CW5 stated that he was in the drunk tank first, then two other guys were put into the cell with him. CW5 did not know what time AP was brought into the cell, but stated that AP and another male were brought in at the same time. CW5 stated that he did not see any police officer use any force on AP.

The Pas Paramedic Personnel

PW1 stated that he and PW2 were dispatched to a call regarding a cardiac arrest at The Pas RCMP detachment at approximately 1:30 a.m. on October 6. PW1 stated that they arrived on scene within two minutes of the dispatch. PW1 stated that they entered the cell area to find the RCMP members performing CPR on AP, who was laying on his back in a cell. There was an AED (automated external defibrillator) unit attached to AP. There were no visible signs of trauma around AP, leading him to believe that nothing suspicious had taken place to cause the death. PW1 stated that he was advised that AP was in custody under the IPDA. Aside from chest compressions and rescue breathing, he did not see any RCMP members have physical contact with AP.

PW2 stated that at 1:29 a.m. on October 6, he and PW1 were dispatched to the The Pas RCMP detachment regarding a cardiac arrest call. PW2 stated that they arrived at 1:32 a.m. and went to

cell 7 where he observed AP laying supine in the middle of the room. An AED was connected and CPR compressions were being performed. PW2 stated that at no time in his presence was there any signs of life and that AP was pale and cold to the touch. PW2 stated that PW1 declared AP deceased at 1:56 a.m.

Witness Officers:

WO1 was on shift at the RCMP, The Pas detachment beginning in the evening of October. 5 into the morning hours of October 6. WO1 stated that at 6:47 p.m. on October 5, a dispatch call was received concerning a male found behind a building in The Pas. Two RCMP members were dispatched to this call. WO1 noted that it was a very busy evening at the detachment. WO1 stated that at 1:28 a.m., now October 6, she had just finished logging in a prisoner into cells and decided to conduct a *"physical check"* of the prisoners in the cells, part of her regular duties. WO1 stated that she looked into drunk tank where there were three males within. AP was laying on his back and had some discoloration to his hands and face. WO1 stated that she could not tell if his chest was rising and falling, so she knocked on the door and got the attention of the other two males in the cell. WO1 asked one of the males to check on AP. WO1 stated that the male said there was no pulse. WO1 radioed for assistance and entered the cell. WO1 stated that AP was not breathing and his hands and face were cold. WO1 requested an ambulance be called and commenced chest compressions. Additional RCMP members attended the cell area and removed the other two males (CW4 and CW5). On the arrival of the ambulance, paramedics took over the treatment of AP. WO1 stated she was advised that paramedics had pronounced AP as deceased. WO1 advised that AP was not being touched by the other males when she checked on AP. WO1 stated that CW2 told her that she had last checked AP at 1:15 a.m. She was unsure if that was a physical check or a camera check (viewing AP on the monitor only).

WO2 was on duty and working at the RCMP The Pas detachment on October 5. WO2 stated that his initial interaction with AP that day was at approximately 7:00 p.m. WO2 stated that just prior to that, he was assisting in detaining CW4 in a police cruiser when a dispatch call was received noting that another male was passed out behind a nearby building. WO2 stated that they attended this new location and located AP, who was passed out. WO2 stated that he was able to rouse AP and noted a strong odor of liquor on his person. AP was also slurring his words. An empty bottle of Listerine was located nearby. Based on these observations, WO2 stated that he concluded that AP was drunk in public and was detained pursuant to the IPDA. AP was placed into the police cruiser car. WO2 stated that they returned to the detachment and both CW4 and AP were placed into the drunk tank. WO2 stated that he was well acquainted with AP for years while working in The Pas and that he was very well-liked by police. That night, AP did not complain of any ailments or injuries. WO2 stated that he also knew that AP had issues standing and walking. As a result, and given AP's drunkenness, WO2 stated that RCMP members used a wheel chair to wheel AP into the drunk tank. This was at 7:08 p.m. WO2 stated that a third male, CW5, was already in the drunk tank. He advised that there was no fuss or fight with AP at any time, that he had not been handcuffed, and that he had detained AP for his own safety. At approximately 1:15 a.m., now October 6, WO1 called for assistance at the drunk tank. WO2 stated that he was not sure of the time he returned to cells. WO2 stated that he was asked him to check on AP, who was laying on his back in the middle of the cell with his head toward the north and his feet toward the door. WO2 stated that all attempts to rouse AP were unsuccessful and he told WO1 that AP was unresponsive. WO2 stated that he commenced CPR on AP at 1:35 a.m. Other RCMP members

assisted in performing CPR. They continued with chest compressions even after Paramedics arrived on scene.

WO3 was on duty through the evening of October 5 and into the morning hours of October 6 at the RCMP The Pas detachment. WO3 stated that at 1:20 a.m., he was on route to the detachment when he heard a radio broadcast from WO1 requesting assistance in cells. WO3 stated that he arrived at the detachment within two minutes and immediately attended the drunk tank. WO3 stated that he saw WO1 performing CPR on a male laying on the floor, later identified as AP. WO3 stated that he relieved WO1 and continued with CPR. Other RCMP members were present and assisted in performing CPR. WO3 stated that AP was very well known and well liked by police. WO3 stated that he had personally dealt with him a few times while working in The Pas during the past year. WO3 stated that AP was *"generally a good guy"*.

Cell Video

IIU investigators reviewed the surveillance video recordings from The Pas detachment:

- 7:11 p.m. - AP is brought into cells by WO2. AP lays down on the floor, in the middle of the cell and appears to fall sleep on his back. AP is situate between two other males (CW4 and CW5), who were in the cell prior to his entering.
- 8:14 p.m. – CW4 rolls over and while laying on his stomach, rests his left foot across AP's neck/face area. This action appears completely accidental.
- 8:54 p.m. – CW4 removes his foot from AP's face/neck area and continues sleeping.
- Throughout the remainder of the video surveillance AP does not appear to move again.
- 1:29 a.m. - the cell window cover is opened and someone is looking into the drunk tank.
- 1:30 a.m. - CW5 gets up and appears to be checking AP's neck area (searching for a pulse?). CW5 appears to be speaking with an RCMP member on the other side of the cell window/door.
- 1:31 a.m. – WO1 enters the cell and checks on AP. WO2 then enters the cell. WO2 appears to send CW4 and CW5 out of the cell. WO2 attends to AP and attempts to rouse him.
- 1:33 a.m. - two more RCMP members enter the cell as WO1 begins chest compressions on AP.
- 1:37 a.m. - paramedics entered the cell and began working on AP as RCMP members continue CPR.
- 1:59 a.m. – RCMP members and paramedics cease resuscitation efforts.
- 2:05 a.m. - paramedics exit the cell. The cell door was closed and AP's body is left in cell.

Autopsy and Toxicology Reports

AP's autopsy was performed on October 8. In addition, the CME viewed the surveillance cell video particularly where another male's foot/leg appears to have been laying across the Affected Person's neck/face area.

Among the initial findings, the CME advised that AP had a massively enlarged heart and severe coronary disease.

The Toxicology Report showed that AP had a blood alcohol reading of 378 mg% (approximately 4.5 times the legal limit to operate a motor vehicle). This range is in the near lethal levels. According to the Toxicology Report anything greater than 300 mg% can cause "*significant mental and motor dysfunction including marked incoordination, decreased level of consciousness, diminished reflexes, coma and potential death due to respiratory depression".*

The cause of death was noted:

- *ACUTE ALCOHOL TOXICITY and ALCOHOLIC CARDIOMYOTPATHY (disease of the heart muscle),*
- *CORONARY ARTERY ATHEROSCLEROSIS and*
- *EXTERNAL NECK COMPRESSION*

The CME noted that AP was a very unhealthy man, suffering from a massively enlarged heart and severe coronary disease. However, the CME had other concerns, describing this incident as "*a complicated case, and determination of the cause of death incorporates many significant findings".*

The CME summarized his opinion regarding AP's death as follows:

> *On October 5th, 2019, the decedent was picked up by RCMP after being found "passed out" in an outdoor area, before being lodged in a cell with two other intoxicated individuals. Early the following morning, he was discovered to be unresponsive in the cell and not breathing, and resuscitation was unsuccessful. When surveillance of the room was reviewed, it was discovered that another individual rolled over while asleep, with one of his legs coming to rest across the decedent's neck. The situation persisted for approximately 40 minutes before the other individual turned over again, lifting his leg from the decedent's neck.*
>
> *A complete autopsy was performed on October 8, 2019. Findings included an enlarged dilated heart consistent with alcoholic cardiomyopathy, as well as multifocal moderate to severe calcific coronary artery atherosclerosis (buildup of plaque in the arteries). Examination of the neck revealed no evidence of blunt trauma to the neck, and no petechial hemorrhages were noted on the face or in the eyes. Toxicology samples taken at the time of autopsy revealed an extremely high blood alcohol level (378 mg /dL)…This (surveillance video) demonstrates the decedent being brought in by guards and laid on the floor in a supine position, with two other individuals apparently asleep on the floor in the room. After being placed on the floor, the decedent remains motionless for a substantial period of time (approximately one hour). At approximately 8:15 pm, one of*

the other inmates is seen to roll over, with his calf coming to rest across the decedent's neck. It is unclear if the leg is also across the jawline, with occlusion of the mouth and or nose. Over the next five minutes, the decedent is seen to move both arms periodically, bringing them up to touch the leg across his neck but making no organized effort to remove the leg. At approximately 8:20 pm, the decedent lowers his arms for the final time and does not move any further for the duration of the video. The other inmate's leg remains across his neck for approximately 40 minutes before he rolls over again, removing the leg. Due to poor video quality, it is not possible to see if the decedent is breathing at the time the leg is removed from the neck.

At 1:31 am on October 6, a guard comes into the cell and checks on the decedent. After finding him to be unresponsive and pulseless, resuscitation was undertaken, but death was pronounced at 1:56 am.

This is a complicated case, and determination of the cause of death incorporates many significant findings. The underlying heart disease in the form of severe alcoholic cardiomyopathy and atherosclerotic coronary artery disease is sufficient to cause sudden death in and of itself. Similarly, a blood alcohol level of 378 mg/dL is a life-threating concentration that could be fatal in its own right. These two factors therefore cannot be ignored, and are felt by the author to represent major contributing factors in causing death.

However, review of the surveillance video from the holding cell presents compelling evidence that external neck compression also played a role in causing death. After being brought into the cell, the decedent was unresponsive and motionless. However, after the other inmate's leg came across his neck, the decedent moved his arms periodically over a period of five minutes, repeatedly touching the leg across his neck but making no organized effort to remove it. Following this, he remains motionless until being discovered unresponsive by guards several hours later.

The fact that the decedent responded to the presence of the leg across his neck despite being extremely intoxicated indicates that the physiological stress the leg was producing must have been significant. The fact that this movement continued for approximately 5 minutes before ceasing altogether suggests a progressive asphyxia component, followed by complete unresponsiveness and subsequent death.

The absence of significant internal injury in the neck is not surprising given the lack of a struggle. Compression of internal neck structures can occur with relatively small amounts of weight on the neck. It is also possible that the leg across his neck was partially or even at times completely occluding his mouth and nose, leading to a possibility of smothering. Smothering does not leave any distinctive evidence at autopsy.

Conclusion:

Following the completion of this investigation, the civilian director had concerns that the circumstances of this matter suggested that a number of individuals, potentially including guards and inmates in addition to police personnel, may responsible for the death of AP. On the basis of these concerns, it was determined that the completed investigative file and materials be forwarded to Manitoba Prosecution Service (MPS). The civilian director requested a review and

opinion on whether any Criminal Code charges should be authorized against any individual referenced in this investigation.

Following the review of the complete IIU investigative file, MPS provided a written opinion, in which it was stated:

> *"Manitoba Prosecution Service (MPS) has reviewed the IIU investigation of the circumstances of the death of [AP] at the time of his detention at the RCMP The Pas detachment pursuant to the IPDA. While it is always in the public interest to hold police officer conduct accountable, there must also be a reasonable likelihood of conviction for MPS to prosecute a matter, if indeed any investigation reveals any illegal wrongdoing. In this case, after considering all of the evidence, it is concluded that there is no basis for any criminal charges. When MPS is consulted for charge opinion in any criminal matter, we employ the same standard for proceeding with criminal charges"*

The IIU investigation is now complete and this file is closed.

Final report prepared by:
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Independent Investigation Unit
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