IIU | INDEPENDENT INVESTIGATION UNIT OF MANITOBA

FINAL REPORT: IIU concludes investigation into death in presence of WPS officers

On February 10, 2020, Winnipeg Police Service (WPS) notified the IIU that a male (later identified as the Affected Person (AP)) was transported to the Health Science Centre (HSC) following a confrontation with WPS officers, where he was pronounced deceased.

The salient portion of the written notification read as follows:

> *"On February 10, 2020, a Winnipeg Police Service Unit was dispatched to a domestic dispute to an address on Listowel Bay where they were confronted by a distraught male who was armed with a knife. This male appeared suicidal and had the knife pointed at his chest. Police were not successful in disarming the male through conversation and attempted to deploy a CEW to control the situation; however, he pushed the knife into his chest. The male was transported to the hospital via ambulance; however, died from his injuries..."*

As this matter concerned the death of a person that may have resulted from the actions of a police officer or police officers, IIU assumed responsibility for this mandatory investigation in accordance with section 65 of The Police Services Act (PSA). A team of IIU investigators was 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 the Manitoba Police Commission to appoint a civilian monitor.

WPS information obtained by IIU investigators included:

- WPS Investigative Summary;
- WPS officers' notes and narrative reports;
- Forensic Identification Unit report and photographs;
- WPS call history;
- 911 call recordings;
- WPS radio transmissions recordings;
- Conductive Energy Weapons (CEW) download reports and analysis; and
- an autopsy report respecting the AP.

Following the review of the agency information, there was a dearth of information at the outset about whether any WPS officers were directly or indirectly involved in the cause of the AP's death. As such, the civilian director was not prepared to designate a subject officer (SO) at that time. This decision was deferred until more information was obtained through this investigation. The two WPS officers who were directly involved in the confrontation with AP and used CEWs were designated as witness officers (WO1-2). IIU investigators interviewed a civilian witness (CW) and reviewed a report from a WPS subject matter expert (SME) on CEWs.

Facts and Circumstances

Civilian Witnesses:

CW was in a live-in relationship with AP. CW states that around 9:30 a.m. on February 10, she was at the residence to get some belongings as she was in the process of moving out. AP was present at the residence at this time. CW states that AP was sitting in an armchair and drinking from a bottle of vodka. CW states that AP appeared to be heavily under the influence of alcohol and may have taken some sleeping pills. CW states that there was a physical altercation between the two of them. CW states that AP made several comments that he would commit suicide. CW states that AP has previously attempted to take his own life. CW states she contacted police that day, because of the altercation that morning and because she was concerned for AP's safety. CW states that she met two WPS at an alternate address. CW states that she then drove to the residence and that the WPS officers followed her. CW states that she wanted to remove a dog from the residence then allow police to enter and deal with AP. CW states when she entered the residence, and walked towards a back patio door, she noticed AP's arm and hand, could see he was smoking and heard him say *"hello"*. CW states that she could not see whether AP was in possession of a weapon. CW states that she allowed the police officers to enter the residence through a side door and directed them to the living room, where AP was sitting on a recliner. CW states that she left the residence with the dog.

Witness Officers:

WO1 states that at approximately 6:40 p.m., he, WO2 and CW, attended the residence. WO1 states that he and WO2 were investigating a domestic incident in which CW alleged that AP assaulted her and they intended on arresting him. WO1 states that CW also reported that AP had been acting suicidal. WO1 states that once they were allowed into the residence, they encountered AP in the living room and he was holding a knife to his chest. WO1 states that AP appeared intoxicated and refused to drop the knife, despite repeated commands by police. WO1 states that AP began pushing the knife into his chest as both officers deployed their CEWs at him with the intent to incapacitate him. The CEWs were ineffective and the AP plunged the knife deeper into his chest. A second deployment of the CEWs was also ineffective. WO1 states that AP removed the knife after a brief moment and instantly became medically distressed. WO1 states that emergency medical services were requested to rush to the scene. WO1 states that there was no information to suggest AP was in possession of a knife when the police officers entered the house.

WO2 states that he, WO1 and CW attended the residence at approximately 6:40 p.m. that day. WO2 states that the police officers were investigating a domestic assault that had allegedly occurred earlier in the day. WO2 states that CW had requested officers to attend the residence with her to retrieve her dog. WO2 states that CW advised that AP had expressed suicide thoughts recently. WO2 states that upon entering the residence, police officers encountered AP in the living room and he was holding a knife to his chest. WO2 states that AP was intoxicated and refused to relinquish the knife, despite repeated requests by police officers. WO2 states that both he and WO1 deployed their CEWs at AP, without effect. WO2 states that AP then plunged the knife into his own chest. When AP pulled the knife out and dropped it, WO2 states that an ambulance was called and emergency medical services were requested to attend the scene. WO2

states that he had no prior knowledge when he entered the residence that AP was in possession of a knife.

Subject Matter Expert:

SME is a member of the WPS officer safety unit and is a CEW instructor.

SME inspected the CEW issued to WO1 and advised that at 6:43:45 p.m., it was initially activated. At 6:43:54 p.m., cartridge 1 was deployed. SME then states that at 6:44:21 p.m., cartridge 2 was activated and was deployed at 6:45:15 p.m. The CEW was made safe at 6:45:19 p.m. The total event time of the CEW activation and deployment was 94 seconds.

SME inspected the CEW issued to WO2 and advised that it was initially activated at 6:43:57 P.M. At 6:44:07 p.m., cartridge 1 was deployed. Cartridge 2 was deployed at 6:44:19 p.m. and at 6:45:31 p.m., the CEW was made safe. The total event time is 94 seconds.

SME states that there had been a combination of good and poor connections on AP's person and variables like distance to subject, probe spread, deployed probe location and subject positioning all play a major role in the effectiveness of a CEW deployment.

Pathology and autopsy report:

An autopsy was performed on AP on February 11, 2020. On January 18, 2021, IIU investigators received the final autopsy report. The cause of death was documented as a *"stab wound of the chest wall"* and included a brief description of the injury as a *"stab wound of the left chest wall penetrating the heart with associated hemopericardium[1] and bilateral hemothoraces[2]"*. The wound direction is slightly downward, rightward, and backward, penetrating at least 7 cm into the chest.

At least 10 separate hesitation type incisions[3] were noted on AP's left forearm to his hand.

Evidence of the CEW deployments were noted on AP's person. The use of the CEWs had no contributing role in the death of AP.

Toxicology results AP disclosed the presence of prescribed medication and a blood alcohol level of between 207 and 335 mg% (between 2 ½ and 4 times the legal limit to operate a motor vehicle).

Conclusion:

This investigation must consider whether the actions of any or all of the subject officers who responded to the call for service caused, or in any way contributed, to the death of AP.

The following factors have been determined:

- WO1 and WO2 were lawfully placed within the residence and were in the lawful execution of their duties during their interaction with AP;

[1] Refers to the presence of blood within the pericardial cavity, i.e. a sanguineous pericardial effusion. If enough blood enters the pericardial cavity, then a potentially fatal cardiac tamponade can occur.

[2] An accumulation of blood within the pleural cavity. The symptoms of a hemothorax may include chest pain and difficulty breathing, while the clinical signs may include reduced breath sounds on the affected side and a rapid heart rate.

[3] Usually superficial and parallel incisions that are self-inflicted in places where major vessels are near the skin surface, in an attempted suicide.

- WO1 and WO2 attended the residence with intent to arrest AP in furtherance of their investigation into the CW's allegation of assault;
- WO1 and WO2 were aware that AP had exhibited suicidal ideations;
- Neither WO1 nor WO2 were aware of any information that AP was in possession of a weapon, and specifically a knife, when they were permitted entry into the residence;
- When WO1 and WO2 had their initial contact with AP in the living room, he was holding a knife towards his own chest;
- WO1 and WO2 used verbal commands to convince AP to drop the knife;
- When AP began to plunge the knife into his own chest, WO1 and WO2 used their respective CEWs in an attempt to incapacitate AP and prevent him from further harming himself. Unfortunately, the use of CEWs was not successful;
- The cause of death was a self-inflicted stab wound to the chest and heart. The CEW use was not a factor or contributory cause of death.

Based on the above-noted factors, the IIU's civilian director has concluded that the AP died by suicide. There is no evidence to support a finding that any police officer contributed to the cause of the AP's death. The use of the CEWs was for the purpose of incapacitating AP and preventing more harm to him. Consequently, there is no evidence in this matter that would justify the designation of any of the police officers as a subject officer. As a result, there is no further requirement or need to continue with this investigation.

A note on timing. The bulk of the IIU investigation was completed in May 2020, pending the pathologist's findings and conclusion as contained in the official autopsy report. The official autopsy report was received from the Office of the Chief Medical Examiner on January 18, 2021, and the IIU investigation was concluded shortly thereafter.

This file and investigation is now closed.

Final report prepared by:
Zane Tessler, civilian director
Independent Investigation Unit
February 17, 2021

Ref 2020-008