SiRT | SERIOUS INCIDENT RESPONSE TEAM

Summary of Investigation

SiRT File # 2023-062

Referral from

Saint John Police Force

New Brunswick

December 14, 2023

Erin E. Nauss
Director
June 19, 2024

MANDATE OF THE SiRT

The Serious Incident Response Team ("SiRT") has a mandate under the Nova Scotia *Police Act*, and through agreement, under the New Brunswick *Police Act,* to investigate all matters that involve death, serious injury, sexual assault, and intimate partner violence or other matters determined to be of a public interest to be investigated that may have arisen from the actions of any police officer in Nova Scotia or New Brunswick.

At the conclusion of every investigation, the SiRT Director must determine whether criminal charges should result from the actions of the police officer. If no charges are warranted the Director will issue a public summary of the investigation which outlines the reasons for that decision, which must include at a minimum the information set out by regulation. Public summaries are drafted with the goal of including adequate information to allow the public to understand the Director's rationale and conclusions.

INTRODUCTION

On December 14, 2023, the SiRT received a referral from the Saint John Police Force ("SJPF"). The Affected Party ("AP") was housed in SJPF cells on December 14, 2023, and went into medical distress. Officers called for an ambulance and administered first aid for approximately 28 minutes. When paramedics attended, the AP was pronounced deceased. In this matter, three officers were identified as Subject Officers ("SO"s). The SiRT concluded its investigation on May 8, 2024.

The decision summarized in this report is based on evidence collected and analyzed during the investigation, including, but not limited to, the following:

1. Civilian Witness Statements (2)
2. Witness Officer Reports (6)
3. Video Recordings from Prisoner Care Facility and Cell
4. Police Radio Transmissions
5. Call for police service
6. Body Camera Footage
7. Forensic Identification report
8. Final Postmortem, Coroner's, and Toxicology Reports
9. SJPF Care and Handling of Detainees Policy and Detention Policy

INCIDENT SUMMARY

The SJPF were contacted on December 14, 2023, at 4:25 pm by a female requesting their assistance to remove the Affected Party ("AP") from the basement of a business. The AP was a 48-year-old male who appeared to be intoxicated. He had been removed from the same basement the day before by SJPF, and he was arrested for being intoxicated in a public place, housed in police cells, and

released. The AP was known to police and was often housed in cells under the New Brunswick *Intoxicated Persons Detention Act*, which states that when a peace officer finds a person who is intoxicated in a place to which the public has access, they can take the person into custody. After the initial December 14th call, SJPF received two additional calls from employees of the business, each time requesting police attend to remove the AP. With each call the behaviour of the AP seemed to be escalating, and he was beginning to damage property.

In the course of the investigation, the SiRT interviewed the building owner, Civilian Witness #1 ("CW1"). CW1 had previously employed the AP, and recently attempted to help him with employment and his struggles with alcohol and drugs. CW1 stated that the AP had been experiencing homelessness and he did not mind him sleeping in the basement garage of the building, until he became disruptive and abusive to the staff of the upstairs business.

Two members of the SJPF, Subject Officer #1 ("SO1) and Subject Officer #2 ("SO2") arrived at the business at approximately 5:26 pm. Subject Officer #3 ("SO3") arrived shortly thereafter. The entirety of SJPF interactions with the AP are captured on body camera and cell block video. SO1's body camera captures her meeting with one of the complainants who called the SJPF. He stated that the AP was intoxicated and had been threatening staff, arguing that staff owe money to the building owner (CW1), who had been trying to help out the AP.

The AP was not combative with police and he was taken into custody. They departed the scene at approximately 5:37 pm. SO1 attempted to make arrangements to drop the AP off at a residence but was not able to find someone fit to take him in their care.

A complete review of the body camera video shows that the AP was not advised by any of the SOs that he was under arrest. He was not read his *Charter* rights or the police caution, as required by law. Furthermore, it does not appear that he was searched before being placed in the police vehicle.

The SOs and the AP arrived at the SJPF police station at 5:43 pm. The AP was not happy to be at the station, and he initially refused to exit the vehicle. Body camera footage shows SO1 ask the AP what is on his shirt. Although body camera footage shows his shirt was dry when entering the police vehicle, when he exited there is liquid spilled down the front of his shirt. SO1 then retrieved 2 bottles of vodka from the AP's pocket. One pint was full and sealed, the other was open and approximately ¾ empty. There is no evidence to definitively determine when the alcohol was consumed. The AP fell once he exited the police vehicle. He was transported to a cell in a wheelchair, but cell camera footage shows him walk to the cell door and lean on it with his arms. Camera footage at 5:57 pm shows the AP fall backwards and land on the floor of the cell between a wall and a bench. At this point, the camera footage stops as the camera is activated by motion.

There did not appear to be any movement inside the AP's cell for approximately 1 hour and 6 minutes. Cell video footage shows that the Commissionaire assigned to work in cells, Civilian Witness #2 ("CW2"), conducted the necessary 15-minute inspections required by SJPF policy, with the exception of one instance where the check was performed 6 minutes and 9 seconds later than required by policy, at 6:28 pm. CW1 stated this was due to the fact that he was assisting the Station Supervisor, Witness Officer #2 ("WO2"), with a young person in cells who had attempted to harm themselves. This was confirmed by WO2's police report.

Witness Officer #1 noted that earlier in the evening he checked on the AP, and he was breathing and making a snoring sound. Later that evening, WO1 was in his office when he heard a call for an ambulance on the police radio.

At 7:00 pm CW2 conducted his check on the AP and knocked on the cell window. He remained at the cell for 1 minute and 36 seconds, then left the area to call for help. CW2 returned and opened the meal hatch to try to get a response from the AP. At 7:03 pm, officers discovered the AP laying on the floor, and he was not responsive. An ambulance was called. Witness Officers #2, #3, and #4 ("WO2", "WO3", "WO4") administered CPR and advanced first aid for approximately 28 minutes. WO2 noted that the AP was snorting and snoring approximately every 20 seconds and had faint breathing. WO4's police report states that he found a Bic lighter in the AP's pocket just prior to commencing CPR. Officers moved the AP to the hall to make room for paramedics. At this point, they noticed he was no longer breathing and they could not find a pulse. Once paramedics arrived, CPR was continued; however, the AP was pronounced deceased at the scene.

The coroner attended police cells and seized medication the AP had in his personal effects. The Postmortem Examination report concluded the cause of death was ethanol (480 mg/dl) and diazepam (71 ng/ml) toxicity. The Medical Examiner determined the cause of death to be ethanol and diazepam toxicity. The death was found to be accidental.

RELEVANT POLICIES

SJPF has policy regarding the handling and care of detainees. It requires an inspection of detainees every 15 minutes, and to immediately report to the supervisor if a person appears sick or injured.

It also states that if a detainee appears to be sleeping, extra care must be taken to ensure the detainee is breathing properly, especially if the detainee is intoxicated. If there is any doubt, the detainee should be shaken to awaken them and ensure that the detainee is not unconscious.

The policy also states the on-duty Supervisor will be responsible for the security and safety of detainees held in the detention facility.

RELEVANT LEGISLATION

Criminal Code:

Duty of person arresting
29 (1) It is the duty of every one who executes a process or warrant to have it with him, where it is feasible to do so, and to produce it when requested to do so.

Notice
(2) It is the duty of every one who arrests a person, whether with or without a warrant, to give notice to that person, where it is feasible to do so, of
(a) the process or warrant under which he makes the arrest; or
(b) the reason for the arrest.

Failure to comply
(3) Failure to comply with subsection (1) or (2) does not of itself deprive a person who executes a process or warrant, or a person who makes an arrest, or those who assist them, of protection from criminal responsibility.

Duty of persons to provide necessaries
215 (1) Every one is under a legal duty
(a) as a parent, foster parent, guardian or head of a family, to provide necessaries of life for a child under the age of sixteen years;
(b) to provide necessaries of life to their spouse or common-law partner; and
(c) to provide necessaries of life to a person under his charge if that person
> **(i)** is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and
> **(ii)** is unable to provide himself with necessaries of life.

Offence
(2) Every person commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse to perform that duty, if
(a) with respect to a duty imposed by paragraph (1)(a) or (b),
> **(i)** the person to whom the duty is owed is in destitute or necessitous circumstances, or

(ii) the failure to perform the duty endangers the life of the person to whom the duty is owed, or causes or is likely to cause the health of that person to be endangered permanently; or

(b) with respect to a duty imposed by paragraph (1)(c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.

Criminal negligence
219 (1) Every one is criminally negligent who
(a) in doing anything, or
(b) in omitting to do anything that it is his duty to do,
shows wanton or reckless disregard for the lives or safety of other persons.

Definition of *duty*
(2) For the purposes of this section, ***duty*** means a duty imposed by law.

Causing death by criminal negligence
220 Every person who by criminal negligence causes death to another person is guilty of an indictable offence and liable
(a) where a firearm is used in the commission of the offence, to imprisonment for life and to a minimum punishment of imprisonment for a term of four years; and
(b) in any other case, to imprisonment for life.

LEGAL ISSUES & ANALYSIS

Section 29 of the *Criminal Code* describes the duty imposed on those who make an arrest. Subsection 29(2) requires notice to be given to the person arrested, where it is feasible to do so, of either the process or warrant under which the arrest is made or the reason for the arrest. In the present situation, it does not appear that the AP was advised that he was under arrest, nor was he read his *Charter* rights or provided the police caution. There is caselaw which sets out how this is determined and the impact of the failure to give notice.[1]

However, this does not necessarily impact the potential for criminal liability related to the AP's death. Subsection 29(3) of the *Criminal Code* notes that non-compliance with the requirements of

[1] There have been cases that have found that the failure to advise a drunken accused of the fact that he was under arrest and the reason therefor, was fatal to a charge of assaulting a peace officer in the execution of his duty.[1] However, a person need not be informed if their mental condition was such that they would not be able to appreciate what was being said.[1] Caselaw has found that a person need not be informed if the circumstances are obvious; for example, if the person knew the police were arresting them for being drunk in a public place.[1]

Section 29 does not by itself deprive the person making the arrest of protection from criminal responsibility found elsewhere in the Code.

In effect, if it was found that the AP was held in violation of his rights under the *Criminal Code* or the *Charter*, it does not mean that the SOs cannot avail themselves of the protections and defences available to them related to the AP's death.

Section 215 of the *Criminal Code* sets out when someone has a legal duty to provide another person with the necessaries of life. Clause 215(1)(c) deals with a person who has the charge of another person who is unable to provide the necessities of life to themselves, which includes those in police custody. Caselaw has found that a failure to provide medical treatment can amount to "necessitous circumstances" and lead to criminal liability. The offence is established, in part, on conduct that amounts to a marked departure from the level of care that a reasonable person would have exercised in the circumstances. A police officer's subjective belief that a person did not require medical attention is not a lawful excuse; however, the standard to be applied is that of a reasonable person in the shoes of each officer.

For criminal negligence, a person is criminally negligent when an act, or omission of an act, shows wanton or reckless disregard for the lives or safety of other persons. There must be a marked and substantial departure from what a reasonably prudent person would do in the circumstances. For criminal negligence causing death, the act or omission must have caused the death.

Despite the issues with the arrest and detention of the AP, when considering the care afforded to the AP while he was in police custody, I am satisfied that the SOs conducted themselves with due regard for the AP's health and well-being. It would be unreasonable to assume the AP was in any medical distress based on his initial contact with police and their experience in dealing with intoxicated persons. When transported to the police station, although the AP required a wheelchair to be transported from the vehicle, he stood and walked at the cell. I cannot find there was a substantial and marked departure from what a reasonable person would do in the circumstances. The investigation revealed that SJPF Policy was followed regarding cell checks, with one exception that was reasonable due to the circumstances. While merely following policy is not a defence for criminal conduct, it can assist in determining what a reasonably prudent person would do in similar circumstances.

It does not appear that SJPF Policy was followed to attempt to rouse the AP when he appeared to be sleeping to ensure he was not unconscious. However, witnesses stated that they heard the AP snoring. The cause of death was found to be accidental due to ethanol and diazepam toxicity. Care was not taken to search the AP when taken into custody in the police vehicle, as alcohol was found on his person. Similarly, a lighter was found after the AP had been in cells. Despite

these oversights, I do not find that there was a marked departure from the level of care that a reasonable person would have exercised in the circumstances. In order for behaviour to be serious enough to constitute a criminal offence, it must be more than being neglectful in carrying out one's duties. Rather, an officer must have acted in a way that 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. It would have been unreasonable for the SOs to foresee the eventual outcome of AP's condition deteriorating to the extent that it did.

Police agencies have developed policies to outline the responsibilities 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.

Once officers noticed the AP was in distress, they immediately responded to the cell and called for an ambulance and conducted emergency first aid and CPR for an extended period. The actions of WO2, WO3 and WO4 are commendable.

In this matter, three officers were identified as Subject Officers due to their interaction with the AP. A civilian jail guard also interacted with the AP. The New Brunswick *Police Act* does not grant the SiRT jurisdiction to investigate civilian jail guards. However, throughout the investigation, there was no evidence to indicate any criminal wrongdoing on the part of the civilian guard which would warrant a referral to police for investigation.

Despite the tragic death of the AP, I cannot find there was a substantial and marked departure from what a reasonable person would do in the circumstances. Further I cannot find that the actions or omission of actions showed a wanton or reckless disregard for the life and safety of the AP.

CONCLUSION

My review of the evidence indicates there are no reasonable grounds to believe that any of the Subject Officers committed a criminal offence in connection with the AP's tragic death. This was a difficult and unfortunate set of circumstances and the SiRT sends its condolences to the AP's family.