Serious Incident Response Team

Civilian Director's Report
SIRT-NL File No. 2020-020

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Director
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Introduction

On December 17, 2020, an individual died while in the custody of the Royal Canadian Mounted Police (RCMP) in its Happy Valley-Goose Bay detachment. The RCMP notified the Serious Incident Response Team of Newfoundland and Labrador (SIRT-NL) of the incident. Because SIRT-NL was not operational at the time, as director, I engaged the Royal Newfoundland Constabulary (RNC) to conduct an investigation into the incident. SIRT-NL would provide oversight and review of the RNC's investigation.

First, it is important to outline the nature and scope of a review. The purpose of a review is to provide an independent and objective examination of an investigation to ensure the investigators conducted the investigation properly, used best practices and took all appropriate investigative steps. In its review, SIRT-NL also assesses whether there is any evidence of bias, tunnel vision or lack of objectivity on the part of the investigating agency. This is to ensure the public has trust in the investigation and its consequences.

A review is not a second investigation. The focus of the review is on the quality of the investigation into an incident, not the incident itself. In other words, it is not within the scope of our review to determine whether the subject officer(s) acted lawfully during the alleged incident or whether grounds exist to lay charges. The investigative agency, not SIRT-NL, makes that final determination. In overseeing and reviewing the investigation, SIRT-NL can make recommendations and provide input but does not have jurisdiction to order the RNC to take certain steps.

Second, I note SIRT-NL's mandate does not extend to investigating civilian employees of the province's police agencies. Because this investigation focused on several RCMP officers as well as detachment cell guards, who are civilian employees, it must be remembered SIRT-NL's review only pertains to the investigation as it concerns the officers.

Overview

I have made the following substitutions to protect the privacy of those involved:

- "Subject officer #" or "SO#" for the names of the RCMP officers who were the subjects of the investigation;
- "Affected person" or "AP" for the name of the deceased;
- "Witness officer #" or "WO#" for any other RCMP officers who provided relevant information; and
- "Witness #" or "W#" for any civilians who provided relevant information.

The following comes from the RNC Investigative Report:

> On December 17th, 2020 at 6:59 p.m., [Subject Officer 1] and [Subject Officer 2] of the Royal Canadian Mounted Police (RCMP) Happy Valley-Goose Bay (HVGB) detachment responded to a complaint of an intoxicated male at [a local service station] in HVGB, NL. [SO1] was the reporting officer, while [SO2] served as backup. [SO2] arrived shortly before [SO1]. [SO2] conducted police record checks and learned there was a warrant of

arrest for [the affected person] from Halifax Regional Police Service. In addition, there were several other release documents associated to him that had a “do not possess or consume clause.” Officers arrested [AP] on the warrant and for breach of the condition for alcohol. [AP] stood up from the seat. At approximately 7:15 p.m. [SO1] began to transport [AP] in [the police vehicle] to the RCMP holding cells in HVGB, NL. While being transported, [SO1] kept the music radio turned down to listen for any signs of distress. [SO1] could hear [AP] snoring every so often. At approx. 7:22 p.m. [SO1] arrived at the RCMP holding cells in HVGB, NL with [AP]. [SO2] also joined. [AP] was placed in cell 148, which is one of two cells referred to as “drunk cells.” [Witness 1] is a civilian employee with the RCMP/Commissionaires. He was the sole guard working the cells at the time. His shift that day was from 8:00 a.m. to 8:00 p.m. At approx. 9:20 p.m. [Witness Officer 1] observed that [AP] was in the cell and was in the same position she observed him in previously. [WO1] then went to cell 148 and opened the cell window to look in and discovered [AP] was unresponsive. [WO1] requested the guard call for an ambulance. Officers performed medical assistance until the ambulance arrived and conveyed [AP] to Labrador Grenfell hospital in HVGB, NL. At approx. 9:59 p.m. the emergency room doctor called the time of death.

The Investigation

Before the RNC were engaged, initial scene securement and exhibit preservation and collection were carried out by the RCMP. The cell used was secured along with the guard logbooks and AP’s personal property. RCMP members attended the hospital and obtained photos and secured AP’s body. Cellblock video footage was secured along with the information of the attending paramedics.

On December 18, 2020, the RNC sent four investigators to Happy Valley-Goose Bay, NL to begin the investigation. A SIRT-NL investigator, who was assigned to observe the investigation, also attended.

On December 23, 2020, the RNC enacted Major Case Management for this investigation. The Command Triangle (the Triangle) consisted of a team commander, a primary investigator and a file coordinator. In addition to the Triangle, the investigative team consisted of Forensic Identification Support and two field investigators.

The RNC investigation involved the following tasks:

- Investigators obtained:
  - Notes and reports from all RCMP officers involved;
  - The RCMP Policy and Procedure Manual;
  - The RCMP cell block surveillance videos;
  - The results of the autopsy and opinion letter from the Chief Medical Examiner;
  - AP’s medical records;

  - RCMP dispatch recordings; and
  - Prisoner logbooks.
- Statements were taken from several RCMP officers. The two officers who arrested AP and took him into custody declined to provide a statement, as is their right. As stated, their notes and reports pertaining to the incident were obtained.
- Over 40 civilians were interviewed, including the civilian employees of the RCMP who guarded the cells on the night of the incident, friends and family of AP and other individuals known to have had contact with AP earlier on the day of the incident.
- Forensics were conducted.
    - Both Cell 148 and the RCMP vehicle used to transport AP were secured and photographed.

I. RCMP Officer Statements

RNC investigators interviewed several RCMP officers. The two officers who brought AP into custody, SO1 and SO2, declined to provide statements. However, they did provide their notes and reports in relation to the incident.

SO1's Occurrence Report

At 6:59pm on December 17, 2020, SO1 received a call that a taxi driver required assistance at a gas station. The taxi driver (W2) had a passenger (AP) that would not get out of the vehicle. SO2 was in the area and said he would meet SO1 at the location to assist with the call. At 7:05pm, SO1 arrived on the scene. SO2 was on the scene, talking to AP, who was still in the taxi. SO1 went to the passenger side of the taxi with SO2 and could smell liquor coming from that area. AP was slurring his speech and was not making any sense. SO2 gave SO1 a prescription that AP gave to him when SO2 asked AP his name. SO2 completed police checks, which revealed there was a warrant for AP's arrest in Nova Scotia and he was on conditions not to possess or consume alcohol.

SO1 arrested AP on the outstanding warrant and for breach of conditions and causing a disturbance. AP got out of the taxi with the assistance of SO1. AP was unsteady on his feet. The two officers escorted him to SO1's police vehicle. He was unable to get into the vehicle himself so the officers assisted him. The officers placed him inside the vehicle in the prone position. The taxi driver gave the officers a bottle of liquor belonging to AP. SO2 placed the bottle in SO1's vehicle. At 7:11pm, SO1 read to AP his "Police Caution" and "Charter Rights"; however, AP fell asleep and thus did not respond.

At 7:22pm, the officers arrived at the RCMP cells with AP. When in the secure bay of the cells, SO2 joined SO1 in bringing AP to the cells. When AP was out of the vehicle, he fell to his knees. AP would mumble to the officers but he did not make sense. When in cell 148, AP was asked to lay on his stomach so the officers could remove the handcuffs and some clothing. The civilian guard (W1) helped with the removal of AP's pants. SO2 then removed his handcuffs. While removing the handcuffs, SO2 observed that AP had a hospital admitting band on his

wrist. Officers then removed AP's mask and cut the strings out of his sweater. They left AP on his stomach. He was still breathing and he made a yelling noise when the officers were leaving. There were no signs of medical distress.

SO1 noted that AP's actions were what he would expect from a highly intoxicated person rather than someone having any medical distress. The appropriate RCMP form was completed. AP's belongings were booked and the bottle of liquor was poured down the drain.

At 9:15pm, SO1 and WO2 arrived in the cells with another prisoner when SO1 noticed WO1 going into cell 148, where AP was lodged. SO1 went to the cell because WO1 was calling out to AP but was not getting a response. SO1 helped WO2 roll AP over and noticed AP's lips were blue. WO1 could not obtain a pulse. WO1 began compressions while SO1, WO2 and WO3 began looking for a first aid mask to do breathing for CPR. WO1 told the civilian guard (W3, who had replaced the aforementioned W1) to call for an ambulance. WO2 obtained a defibrillator. SO1 went to W3, took the cell phone from her and told the hospital AP was unresponsive, had no pulse and had blue lips. SO1 returned to the cells where officers were still working on AP.

SO1 opened and secured the bay door for the ambulance. When emergency crews arrived, they took over. At 9:25pm, emergency crews decided to transport AP to the hospital. SO1 followed the ambulance to the hospital. At 9:35pm, SO1 arrived at the hospital with the ambulance.

SO1 called WO1, advised the time of death, and requested a camera and fingerprint kit. Shortly after, WO3 told SO1 that WO1 wanted WO3 to stay at the hospital and SO1 was to go back to the RCMP detachment. SO1 returned to the RCMP detachment. He met with WO1 in the cellblock, who told him to complete his report. When he was leaving, he recalled the liquor bottle he threw out after booking AP. He provided it to WO1.

SO2's Occurrence Report

At 7:00pm, SO1 was driving past a gas station and saw a taxi in the parking lot with the side door open. He did not think much of it and continued to drive past. A short time after, police dispatch indicated a taxi driver called from the gas station, stating he had a passenger in the vehicle that would not get out. SO2 told SO1 he would turn around and assist with the call for service. At 7:09pm, SO2 arrived on the scene. SO2 looked in the front passenger seat of the taxi and noticed a male slumped over. The driver said he picked up the male and brought him to the store to get beer. SO2 called the male several times and pinched his right trapezius. The male responded to the pain. He was hard to understand. His speech was heavily slurred and he smelled of liquor. SO2 asked the male several times for his name. The male passed him a prescription with his name on it. AP indicated he was at the hospital earlier that day.

SO1 arrived on the scene while SO2 was conducting a records check on AP. AP was highly intoxicated. He was unstable, unable to care for himself and he had nowhere to go. AP was arrested on an outstanding warrant and for breach of conditions not to consume alcohol. AP got out of the taxi himself and the officers handcuffed him. They escorted him to the police vehicle.

He was able to walk. The officers gave AP several chances to get in the rear of the police vehicle and encouraged him to lift his leg up. AP stated he was unable to do so. The two officers then assisted him in the vehicle and transported him to the RCMP cells. SO1 pulled AP carefully out of the back seat and escorted him to his cell. When in the cell, AP was placed in the prone position on the mat. He was cooperative with the officers. As the officers were exiting the cell, AP mumbled something to them.

At 10:09pm, SO2 received a call from WO1, advising AP passed away while in cells. SO2 returned to the RCMP office and prepared his notes, detailing his involvement in this investigation. At 11:46pm, SO2 completed his notes.

II. Civilian Witness Statements

The RNC investigators obtained statements from over 40 civilian witnesses.

From speaking with those who had contact with AP earlier on the day of his arrest, the RNC investigators were able to generate a timeline of events. It should be noted this information, which I will summarize below, was not known to the RCMP subject officers when they encountered and arrested AP.

At approximately 1:00am on December 17, AP drank a 26-ounce bottle of vodka and consumed about 4-5 ounces of cocaine. He then went to a friend's house. He wanted a place to sleep and was looking for beer and liquor. He had a black eye and a bruised lip. After sleeping for a period of time on the couch, AP went to another friend's house. He was going through alcohol withdrawal and was experiencing tremors. His friend took him to a local medical clinic, where he was assessed. His vital signs were stable. AP told the nurse he had been drinking heavily and thought he had fallen down. He was tender across the right side of his stomach. Because he required further treatment for which the clinic was not adequately equipped, an ambulance transported AP to the hospital.

At the hospital, AP was assessed. He slept most of the day and his condition improved. He was discharged from the hospital around 4:30pm. He told staff he was going home and would not be drinking. After leaving the hospital, he went to the NLC, purchased four bottles of alcohol, and went to his cousin's house. He stayed there for approximately an hour and left, in a taxi, to go to Sheshatsiu.

Witness 2 (W2) – The Taxi Driver

The following is a summary of W2's statement to the RNC:

W2 picked up AP, who was going to Sheshatshiu. AP gave him two $50.00 bills and asked him to stop at the liquor store. AP went in the liquor store for about five to six minutes, returned to the taxi and told W2 staff would not serve him. AP then asked W2 to take him to another store, across the street from the liquor store. AP went in that store for 10-15 minutes. When he came

out, he advised W2 he was denied service. Because AP seemed to be staring off into space, W2 pulled onto the parking lot of a nearby gas station and told AP to get out. AP would not get out and began to fall asleep. W2 opened the car door and shouted at AP to get out but AP did not wake up. W2 then called the RCMP for assistance. The RCMP showed up within four to five minutes. W2 gave the RCMP officers a bottle of alcohol that AP had with him. It was a white plastic bottle - maybe one liter - and was half-empty.

Witness 1 (W1) – Civilian Guard

The following is a summary of W1's statement to the RNC:

Sometime between 7:20pm and 7:25pm, W1 received a call asking him to open the cells. SO1 and SO2 arrived with AP, who was placed in cell 148. AP walked in the cell on his own with some support from the two officers. W1 went in the cell and laid down the mattress for AP. AP was laid on his belly in the cell. W1 collected some items associated with AP, which included a bottle. W1 was unsure if it was empty or full. W1 put the camera for cell 148 on the big screen for monitoring purposes. AP seemed normal. He seemed the same as previous times W1 had dealings with him in the cells. W1's shift ended around 8:00pm.

Witness 3 (W3) – Civilian Guard

W3 relieved W1 and was the guard in charge of monitoring the cells at the time of the incident. The RNC investigator questioned her extensively about the incident as well as RCMP policy and procedures. The following is a summary of W3's statement to the RNC:

W3 had been working at the RCMP building for about 17 years. In relation to the guard position, she was given three hours training on how to complete the logbooks. She regularly receives first aid/CPR training and took a course in fire hazard. W3 said, in relation to the logbooks, she records if the inmates are sleeping and ensures their well-being. She said she is required to check on the inmates every 15 minutes but she usually checks every 12-13 minutes. The cellblock has a CCTV system they use to monitor the inmates. W3 commented that, if the inmates are yelling, walking around, or feet moving, she knows they are ok.

The police officers usually come in during their shifts to check the logbooks and to deal with any issues. They use the books to track the activities of the inmates. For example, if an inmate hits his/her head against the wall, that is recorded so the officers would know how the inmate was injured. The guards do more frequent checks if the inmate is acting up. W3's supervisors tell the guards they must conduct checks every 15 minutes. W3 could not recall when her supervisors last told her this. On the night of the incident, WO1 was the shift supervisor. W3 stated that, if the inmate does not move, they keep an extra eye on the person. She explained that, if she clicked on a cell, using the CCTV system, that cell comes on the big TV screen (12 x 14 inches). If there is still no movement, the guard is required to check on the person (not just using the screen) and they then call the police officer.

There are nine cells in the block and two drunk tanks. The drunk tanks each have a stainless steel toilet, no bed (just a mattress, for safety reasons) and are designated 148 and 138. The drunk tanks are for “really drunk” inmates. The other nine cells have concrete beds. W3 said "really drunk" means the person cannot walk and needs officers for assistance. Often, they have very slurred speech. There is a booking room but, if the person is very drunk, officers sometimes by-pass this room.

W3 said it is regular practice for the guards to monitor, using the CCTV monitor. If something appeared suspicious, the guard would physically look into the cell. When there are many prisoners coming and going, they will deal with the prisoner but monitor the other prisoners already in the cells, using the monitor. The cells have shades on the windows. The cells are about five to six steps from where the guards sit.

W3 said the guards do 12-hour shifts and there is only one guard on shift at a time. One guard is responsible for six inmates and a second guard is called in if there is a seventh inmate. The guards sit at the desk with two monitors. The guards are responsible for watching the inmates.

There is a book of guidance on the cellblock desk, which was written by the RCMP. The book is accessible to all staff. The Commissionaires employ W3 but she has to follow RCMP policy. Since the switchover to the Commissionaires, there have not been any rule changes. W3 said they do read policy and procedure and she thinks the last time she did that was last year.

They sign a blue book after reading policy and procedure, which indicates they understand what they have read. They are required to read the policy once a year. The policies cover how to treat prisoners, what to do in emergencies and protocol to check on inmates every 15 minutes. W3 inputs information into the computer for the prisoners (prisoner’s name, number, time, time of release, age, gender, etc). The information is contained on the RCMP form the officers complete by hand and give to the guards. Guards do not do bookings.

In the booking room, the prisoner is usually sitting down if he/she is not too drunk. He/she is stripped down to one layer of clothing. This is usually done by an officer of the same sex. If no one is available, the guard would do it. The guards decide which cell the inmate will be housed in and, if they required special care, the inmate is usually placed closer to where the guard will be sitting. Once the prisoner is placed in the cell by the officer, the officer locks the door. The guards are only permitted to unlock the doors in case of emergencies. If the matter can wait, they call the police officer and wait.

W3 said the police officers working a shift are not responsible for supervising the guards. The guards have a good relationship with the police officers such that, if they suggest an inmate needs medical attention, the officers would bring the inmate to the hospital. W3 said that often the officers are the ones who decided to take an inmate to the hospital. On two or three occasions in the past, she has told the officer to take the inmate to the hospital and they did. W3 was not sure if guards had the authority not to accept an inmate brought in by the police. It is not a normal practice for the officers to by-pass the guards when placing inmates in the cells. They can keep an eye on the inmates through the cell window.

The normal procedure is for the officer to radio ahead when they are coming in with a prisoner. The guard will open the door from the garage to the cellblock. The guard will stand back and let the officers book the inmate.

The guard shifts run from 8:00am to 8:00pm and 8:00pm to 8:00am. On the changeover, the outgoing guard briefs the incoming guard on what prisoners need to go to court, who is detained until sober, their medications, etc. The rule for drunk inmates is to hold them for a minimum of eight hours and then release them.

W3 said the sudden death of AP happened on Dec 17, 2020. She arrived at work around 7:55pm and relieved W1. W1 told her one inmate came in around 7:25pm and one was released around 4:00pm. W1 said the radio was not too busy. She signed the hour book and began her shift by looking at the CCTV monitor. The inmate was sleeping. She remembers seeing AP's foot move and thought he was fine.

W3 said it was a busy night and the police radio had not stopped. She remembers hearing that two more prisoners were on the way to the cellblock. She checked on prisoner two and he was fine. She then went to open the garage door. SO1 brought in one prisoner and WO3 brought in another. WO1 was in the cellblock and was standing at the desk reviewing a form. While the other officers were dealing with their prisoners, WO1 asked if the prisoner (AP) in the cell was ok. W3 said his foot had moved so he was fine. WO1 suggested they check on him. WO1 entered the cell and touched AP's shoulder while W3 stood at the door.

WO1 turned AP over and shouted he was unresponsive. She then began chest compressions. SO1 and WO2 ran over. At the request of WO1, W3 called for an ambulance. WO1 asked for scissors to cut AP's shirt off and W3 cut the shirt. WO3 used a breathing device for CPR while WO1 did chest compressions. Someone came with a defibrillator and W3 remembers hearing "no pulse found, clear" three times. W3 opened the door for the paramedics and checked on the other three prisoners. The paramedics and police continued to do CPR. The paramedics took AP. Because W3 had prisoners, she went back to check on them. W3 then went to fill in the logbooks. She called her supervisor to update him and he came to the station himself.

W3 said she felt she had done everything she could. The incident happened around 8:20pm. At the start of her shift, W3 saw AP laying on his stomach. She remembers seeing that he was blue when officers rolled him over. She kept saying the prisoners were her priority and she cannot see what else they could have done for AP. The other guard told W3 that AP was very drunk when he came in but W3 said she was not there and did not see him. W3 left work around 10:20pm. She remembers WO3 shut the cell door and secured it with a sticker. W3 has not been back to work since the incident.

On December 17, 2020, W3 did not physically look into AP's cell, but she monitored him using the CCTV. She stated she saw his foot move around 8:10-8:15pm and thought he was fine so she wrote "all ok". She would not have written "all ok" if she did not see movement. AP was laying on the mattress; his head was sideways with his right side on the mattress. His palms were up. W1 told W3 that AP did not pay a taxi and was very drunk, hence why he was arrested and brought in. If the inmate is too drunk, the guards will not accept him/her. The police usually take them to the hospital first or sometimes they take them from the cell to the hospital. She figures AP was responding to the officers as he was placed in the cell. She said the policy at the

cellblock is used with discretion. Neither W1 nor W3 has an issue with telling police if they thought the inmate was too drunk to accept. W3 wrote her report on December 17 at 9:40pm.

III. Cell Block Video

RNC obtained and reviewed the RCMP cellblock video from the night of the incident. The contents of the video are as follows:

- 7:23pm: An RCMP vehicle arrives at the RCMP garage. SO1 exits the vehicle. SO2 arrives. The two officers open the rear passenger door of SO1's vehicle. One officer walks to the rear driver's side door, opens it and appears to lean in. The officer on the rear passenger side appears as though he is attempting to pull AP out of the backseat. AP gets out of the vehicle and falls on his stomach. The officers pick him up to his knees and he gets up himself. Each officer is on either side of AP. They walk through the garage together. One officer goes back to the police vehicle and removes a bottle.

  The two officers (believed to be SO1 and SO2) bring a male (AP) into the cell. AP is handcuffed behind his back. It appears his pants are around his ankles. A male in plain clothes (believed to be the civilian guard - W1) enters the cells. W1 takes a mat from the wall and lays it on the ground prior to the officers laying AP on it. SO2 removes AP's pants and footwear and lays them outside the cell. AP is in the prone position on the mat.

- 7:26:10pm: The officers remove the handcuffs on AP. They remove AP's jacket and lay it outside the cell.

- 8:17:42pm: There is a large tensing around AP's stomach. It is similar to the diaphragm rising in the chest. The tensing is very obvious and dramatic. This tensing occurs periodically until 8:26:33pm. The stomach tensing appears to last longer as time moves on.

- 8:26:44pm: AP is motionless. He remains motionless from this point until WO1 checks on him at 9:24:16pm.

- 9:24:16pm: WO1 enters the cell and approaches the left side of AP. She rolls him over on his back. Simultaneously, another RCMP officer (believed to be SO1) enters the cell.

- 9:24:29pm: AP is moved on his back and both RCMP officers place their hands on his chest.

- 9:24:35pm: WO1 exits the cell and returns within a second. SO1 removes gloves from his pocket.

- 9:24:40pm: Both officers return to AP. It appears WO1 places her hand on AP's upper chest area as if she is checking for vital signs.

- 9:24:46pm: WO1 begins preparing for CPR.
- 9:24:47pm: Two other officers enter the cell.
- 9:24:55pm: WO1 begins CPR compressions.
- 9:25:12pm: It appears the officers place a facemask on AP.
- 9:26:50pm: A female (believed to be civilian guard W3) enters the cell.
- 9:26:59pm: An officer appears with a yellow defibrillator.
- 9:28:20pm: The officer begins placing defibrillator pads on AP's torso.
- 9:30:24pm: CPR protocol continues and a female (believed to be a paramedic) enters the cell. A second paramedic wheels a stretcher into the cell.
- 9:38:17pm: AP is wheeled out of the cell.
- 9:39:31pm: It appears the cell door is closed. There is no one left inside the cell.

IV. Medical Examiner

On December 22, 2020, the Chief Medical Examiner issued the Registration of Death in relation to AP. The date of death was listed as December 17, 2020. The immediate cause of death was determined to be "acute alcohol poisoning".

On January 8, 2021, the medical examiner prepared a letter in response to a series of questions posed by the RNC investigators. Due to the significance of this report to the investigation, I will quote it at length:

> Question 1: What was AP's blood ethanol content when he died?
>
> At the time of his death, his blood alcohol measured 464 mg%.
>
> Question 2: Comment on lethality of alcohol?
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> Most acute alcohol poisoning deaths occur when the blood alcohol is 400 or more, however, deaths have been recorded between 300 and 350 mg. It is possible these lower levels occur when an individual has drunk heavily, [sic] they suffer an irreversible brain injury but may take several hours to die, in which case their blood alcohol is being metabolized and thus alcohol at death is lower, however at levels of 300 and above, alcohol can cause cardiac arrhythmia and may cause death.
>
> It is noted at this time that AP, based on his medical records, is a chronic alcoholic and as such, chronic alcoholics are able to tolerate alcohol and may survive higher

levels than most non alcoholics [sic] could tolerate. I have read that the highest alcohol measured in a male that lived was 1100 mg %, this of course is extra ordinary [sic].

Question 3: Comment on whether or not early medical intervention would have prevented this death?

In order for early medical intervention to prevent death, one must know that a lethal alcohol level is present. Given that AP's blood ethanol was not measured, how would anyone be aware that there was a lethal level present [sic]. As mentioned, he is a chronic alcoholic and may not behave in a fashion typical of people intoxicated. For example, most individuals will become unconscious at 300 mg%.

If his blood alcohol was known or it was assumed that he was in a medical emergency situation, it's possible that medical intervention could have helped. This would require at minimum admitting to an intensive care unit, being placed on a respirator and treated with appropriate fluids and necessary medications. It would however, take approximately 24 hours before his blood alcohol came down to zero. In cases of severe alcohol poisoning, the only treatment to remove alcohol is dialysis and in this case in order to have undergone dialysis, AP would have to have been transported to St. John's, following which it could take anywhere from 2 to 6 hours to set up the dialysis procedure. As such, this approach would prove fruitless.

On this point, the RNC investigator made the following note: "It is important to note in this situation, there is no indication that the responding officers knew [AP] was in medical distress leading up to, during and after their initial interaction with him. Given the information from [the Medical Examiner], if the officers knew he required immediate medical attention, and immediately sought medical attention, [AP] still would have died prior to the arriving at the Dialysis Unit located in St. John's, NL."

Furthermore, treatment would not necessarily prevent irreversible brain injury and death. As such, while it is possible that early medical intervention could have had a positive effect, I believe it would be improbable that it would affect the outcome.

On this point, the RNC investigator noted as follows: "Based on my experience dealing with the Office of the Chief Medical Examiner, and given the facts in this case, I would require a higher threshold than a 'possibility' to formulate grounds to lay criminal charges".

Question 4: Timeline?

While AP's blood ethanol level at the time of his death was measured at 464 mg%, his vitreous alcohol, which lags blood ethanol by approximately 2 hours, was measured at 590 mg%, given [sic] that vitreous often over estimates blood alcohol by 10 to 15 %, this would mean that at the time of his placement in the cells, at 7:25p.m., or there about, his blood alcohol would have been between 520 and 540 mg%. This assumes that death occurred shortly before discovery at 9:24 p.m.

I would also note that it was observed at 8:17 p.m. that AP was having what

appeared to be some large abdominal thrusts, which I have reviewed on the DVD provided. Such abdominal thrusts could be an indication that he was having difficulty breathing or may have in fact stopped breathing at that time. Such movements of accessory muscle such as the diaphragm and abdominal wall are attempts to assist the body in breathing. This was not seizure activity.

I thrust [sic] this answers the questions you posed. I should point out at this time that we are still awaiting the results of definitive toxicology testing since our Drugs of Abuse Urine Screen, indicated the presence of cocaine and benzodiazepines. I note however, that on December 17, 2020, whilst in the emergency room, he did receive cliazepam and ativan, which may account for the positive benzodiazepine in his urine. The presence of cocaine in the urine maybe [sic] a false positive, which will be better assessed by toxicology, however, if cocaine is present, this adds another level of complexity to this case.

I also note that he was admitted on December 17, 2020, at 10:50 in the morning and diagnosed with delirium tremens, a form of alcohol withdrawal. I note no blood alcohol is on the chart. He was released six and a half hours later. Delirium tremens is a sign of alcohol withdrawal, which is a potentially life threatening or lethal condition which usually requires management in a hospital. Since I am not sure if the complete medical records were provided to you, we will continue to seek his medical records and review the emergency room admission to see if a blood alcohol or other assessments were made.

V. Forensics

The RNC Forensic Identification Section was assigned to complete all forensic work for this investigation. The forensics officer seized all exhibits associated with the incident that the RCMP had secured. Among these were the following:

- CCTV of cellblock;
- Black ledger book entitled “Guard Hours”;
- Black ledger book entitled “Prisoner Log Book”;
- 2020 Prisoner Log book 3;
- Prisoner Report document; and
- CD photographs of AP, the RCMP patrol vehicle used to transport AP, RCMP Cell 148 and items located in the cell.

RNC Investigator’s Conclusion

The RNC Investigator concluded as follows (I have included the most salient portions of his conclusion):

The video suggests there were no personal checks of the cells conducted from the time holding cell staff member [W3] began her shift on December 17th, 2020 (8:00pm) to the point [AP] was located by [WO1] on December 17th, 2020 after 9:00 p.m. This was confirmed by the cautioned audio interview of [W3] conducted on December 21st, 2020.

That said, [W3] did indicate she made observations of the inmates using the monitor of the video surveillance system.

…

The RCMP policy directs staff to personally attend the cells at 15 minutes [sic] intervals. A criminal offence is not necessarily committed upon breach of policy. Rather, the officer's actions can only be considered criminal if their actions can be considered a marked departure from the standard of care expected of a reasonably prudent jail guard in the circumstances. W1, supervisor of the holding cells, indicated monitoring inmates using the monitor of the video system provides a clearer manner of checking on inmates.

…

The RCMP policy outlines when an inmate is under the influence of alcohol, staff must complete a rousability check on them every four hours. AP was only at the cells for approximately two hours before being discovered, therefore, by policy, a rousability check was not required.

…

There are no reasonable grounds to believe that any officer or guards actions constitute a marked departure from the standard of care expected of a reasonably prudent officer/jail guard in the circumstances. Therefore, there are no grounds to consider criminal charges of criminal negligence causing death.

The RCMP officers ([SO1] and [SO2]) and guard, [W3], would not have any knowledge of [AP]'s blood alcohol content when in their custody. Furthermore, there was no indication they had any medical concerns for [AP] at any point during their interaction with him. There is no indication that anyone failed to obtain necessary medical assistance. In fact, the moment it was determined that medical intervention was required, officers immediately followed up and administered first aid and contacted the ambulance department who showed up minutes later. This is evident by the statements of the officers and a review of the video surveillance. Therefore, there are no grounds to consider criminal charges of failure to provide the necessaries of life.

There are also no grounds to lay criminal charges related to Criminal Negligence Causing Death, under the Criminal Code, as death was not avoidable. In a letter [the medical examiner], OCME, provided, he indicated "…while it is possible that early medical intervention could have had a positive effect, I believe it would be improbable that it would affect the outcome." In order for this to be considered Criminal Negligence, the death would have had to be avoidable. [The medical examiner] suggests this is not likely the case; death was likely the result with, or without, intervention.

Issues and Conclusion

The issue for SIRT-NL's consideration is whether the RNC investigators carried out the investigation properly and objectively and whether they pursued all appropriate investigative avenues.

Upon review of the investigative file, SIRT-NL has concluded the investigation was comprehensive, complete and in keeping with current recognized investigative standards. Investigators followed the principles of Major Case Management and utilized a Command Triangle (Major Case Manager, Primary Investigator and File Coordinator). In addition to this, the investigative team included Forensic Identification Support and two field investigators. The RNC Investigative Report to SIRT-NL is comprehensive and contains a detailed outline of the investigation. The investigative file is organized, professional and in an easily searchable format.

The RNC team pursued all appropriate avenues of investigation and utilized numerous available methods to gather information. Investigators interviewed (or obtained the written reports of) – all involved RCMP officers. They interviewed over 40 civilians, including friends and family of AP, medical personnel and store clerks who had contact with AP earlier on the day he was arrested by the two subject RCMP officers. The RNC obtained dispatch recordings and CCTV video from the RCMP. The RCMP policies and procedures manual was obtained, reviewed and referenced in the interviews. The autopsy results were obtained and investigators made further inquiries to the Chief Medical Examiner. In short, the investigation was comprehensive and thorough. RNC investigators were cooperative with SIRT-NL throughout our oversight and were open to our recommendations. The SIRT-NL observer was kept apprised of all investigative updates throughout.

SIRT-NL also examined the investigation for evidence of investigational bias, tunnel vision, and/or a lack of objectivity. There was no evidence to suggest any of these issues were present. I have no concerns any bias existed in this investigation.

The goal of this review is to determine whether the investigative agency – in this case, the RNC – conducted and completed the investigation in a manner consistent with accepted investigative standards and best practices. This is to maintain SIRT-NL's objective to ensure public confidence in policing in Newfoundland and Labrador. In this case, these investigative standards and practices were attained.

SIRT-NL recognizes the tragic nature of these cases and is available to provide assistance by explaining our role, process and findings to the subject officers and the family of the affected person.

This file is now concluded.

Final Report prepared by:
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Serious Incident Response Team - Newfoundland and Labrador
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