



Serious Incident Response Team

Civilian Director's Report
SIRT-NL File No. 2025-0005

Stephen Ring
Director
August 4, 2025

Introduction

On January 24, 2025, SIRT-NL received notification from the Royal Canadian Mounted Police (RCMP) advising that AP was found deceased at AP's residence in Gander, NL. RCMP had previously responded to AP's residence on January 12, 2025, following a suicide attempt. Gander RCMP received a request to make a wellness check on January 14, 2025, but officers did not attend in person. On January 15, 2025, Gander RCMP received another request for a wellness check. Officers attended and discovered AP deceased at the residence.

Mandate

SIRT-NL is a civilian led oversight agency that conducts its own investigations into serious incidents. Serious incidents within this context are those involving serious injury, death, sexual offence, domestic violence or any matter of significant public interest arising from the actions of a police officer in Newfoundland and Labrador. Because this matter involved the death of the Affected Person, I directed an investigation into this matter.

The strategy for this investigation was a traditional one focusing on the findings of the Office of the Chief Medical Examiner (OCME), medical records of the deceased, interviewing of the civilian witnesses, RCMP PRO's Records, RCMP Communication Center Phone Recordings, cell phone records belonging to the deceased, along with additional corroborating and / or refuting evidence that was available to investigators at the time. The complexity of the investigation did not merit initiating major case management.

Terminology

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

- "Affected Person" or "AP" for the deceased individual; and
- "Witness #" or "W#" for any civilian who provided relevant information.

Investigation

The SIRT-NL investigation began on January 24, 2025, and concluded on July 25, 2025.

During the investigation, SIRT-NL took the following steps:

- Collected and reviewed findings of the OCME
- Collected and reviewed medical records of AP
- Interviewed four civilian witnesses
- Collected and reviewed RCMP Occurrence Reports, including: Calls for Service, Communication Center Recordings, RCMP Radio Transmissions, and Occurrence Details

- Collected and reviewed cell phone forensic analysis

Overview

On January 12, 2025, members of the Gander RCMP Detachment were dispatched to deal with a suicide attempt by AP. AP was not detained and agreed to be transported to hospital by paramedics. AP left hospital before being seen by a doctor.

On January 14, 2025, AP's friend requested a wellness check because AP had not been seen for a few days. Officers attempted to contact AP via telephone. No officers attended AP's residence with the request being passed from RCMP day shift to night shift. There was no documented reason given for the inaction. The RCMP received another request for a wellness check on January 15 which resulted in officers attending AP's residence and discovering that AP was deceased.

The Affected Person (AP)

Given the nature of this investigation, AP would not have been interviewed.

Civilian Witnesses

Witness 1 (W1)

On April 10, 2025, the SIRT-NL investigator interviewed W1. Following is a summary of the interview:

W1 is the mother of AP who reported that she last spoke to AP on January 11, 2025. On January 14, 2025, W1 attempted to contact AP multiple times without success. W1 reached out to AP's neighbour W2, who also had not seen or heard from him. W1 was informed by W2 that she had contacted the RCMP twice on January 14 requesting a wellness check.

On January 15, 2025, W1 contacted RCMP and was told that a wellness check had been assigned but was uncertain of the outcome. W1 later learned from W2 that AP had died. W1 expressed concern over the lack of communication from police and noted AP's history of mental and physical health issues, including suicidal ideation.

Witness 2 (W2)

On April 11, 2025, the SIRT-NL investigator interviewed W2. Following is a summary of the interview:

W2 was a friend and neighbour of AP. W2 confirmed AP's history of mental health concerns, including frequent suicidal ideation and auditory hallucinations. W2 had been caring for AP's dog for several months and noted that AP had not responded to texts or calls since January 10 or 11, which was highly unusual. W2 reiterated AP's extensive history of mental health issues and frequent interactions with police and paramedics.

Witness 3 (W3)

On April 11, 2025, the SIRT-NL investigator interviewed W3. Following is a summary of the interview:

W3 was a friend of AP. W3 noted that AP was usually seen multiple times daily but had not been seen for four days. She called the RCMP twice on January 14 and again on January 15 requesting a wellness check for AP. W3 received no follow-up and was present when the police and FACT¹ Team entered AP's apartment on January 15.

Witness 4 (W4)

On April 11, 2025, the SIRT-NL investigator interviewed W4. Following is a summary of the interview:

W4 is a nurse and FACT Team Member. W4 stated that AP had been a client of the team since July 2024. AP was diagnosed with borderline personality disorder, depression, anxiety, and chronic suicidal ideation. AP had multiple psychiatric admissions and often left against medical advice.

On January 15, 2025, W4 was alerted by AP's pharmacist that he had missed two treatments. W4 visited AP's residence and spoke with a neighbour who had not seen AP in four days. W4 contacted the RCMP and met with them, officers confirmed AP was deceased.

Subject and Witness Officers

Based upon the evidence collected throughout this investigation and medical examiner's findings, no officers were designated as "subject" or "witness" officers.

Medical Records

On January 12, 2025, at approximately 01:33 hrs, emergency medical services were dispatched to AP's residence following a reported suicide attempt. AP was cooperative with paramedics, walked to the ambulance, and was transported to hospital. AP was triaged and monitored throughout the night. At 04:30 hrs, AP was noted to be resting and no longer experiencing hallucinations. By 07:24 hrs, AP was awake, ambulatory, and assessed as fit to sit in the waiting area. When AP's name was called at 08:30, 09:13, and 10:03 hrs, there was no response, indicating that he had left the hospital without formal discharge.

¹ Flexible Assertive Community Treatment (FACT) teams provide treatment of illness and symptoms, hands-on assistance with daily living activities and recovery support for individuals, usually over the age of 18 years, with serious mental illness and concurrent disorders.

Emergency department records confirm AP's history of depression, anxiety, and chronic suicidal ideation. AP was under psychiatric care and had a pattern of leaving hospital admissions against medical advice.

OCME

The OCME was consulted multiple times throughout the investigation and had full access to AP's medical records and forensic data related to AP's cell phone usage. Based upon the postmortem examination and supporting evidence, the OCME estimated the time of death was between 48 to 72 hours prior to the discovery of AP on January 15.

Cell Phone Forensics

The Royal Newfoundland Constabulary's Computer Forensics Unit conducted a detailed analysis of AP's mobile device activity between January 12 and January 15, 2025. The last known activity was during the afternoon of January 12.

Issue and Conclusion

The issue for my consideration is whether there are grounds to believe that failure to conduct a wellness check constitutes criminal negligence causing death.

AP had an extensive history with the RCMP for **Mental Health Care and Treatment Act** related calls for service. AP also had a known history of suicidal ideation, and his risk of committing suicide was assessed as high by the FACT Team. On January 12, 2025, members of the Gander RCMP Detachment were dispatched to deal with a suicide attempt by AP. AP was transported to hospital by paramedics who took responsibility for AP who had voluntarily agreed to receive medical treatment². AP subsequently left the hospital while in the care of paramedics without being seen by a doctor.

On January 14, 2025, AP's friend requested that the RCMP conduct a wellness check because AP had not been seen for a few days. Officers attempted to contact AP via telephone. No officer attended AP's residence with the request being passed from RCMP day shift to night shift. There was no documented reason given for the inaction. The RCMP received another request for a wellness check on January 15 which resulted in officers attending AP's residence and discovering that AP was deceased.

The CME reviewed the circumstances surrounding AP's death which led him to conclude that the estimated time of death was between 48–72 hours prior to AP being found at his residence on January 15, 2025. The CME also concluded that the death was not suspicious. The CME's report confirmed the estimated time of death and supported the timeline established by phone and hospital

² AP was not detained by RCMP Officers under the MCHTA given that paramedics had accepted responsibility for him and cleared Officers to leave.

data. The estimated time of death was leaning closer to 72 hours prior to AP being discovered by RCMP officers (i.e., January 12, 2025).

The SIRT-NL investigation led to the following factual findings:

- **Failure to Act:** The initial wellness check request on January 14 was not acted upon, and no documentation explained the inaction.
- **Mental Health History:** AP had a documented history of suicidal ideation and frequent interactions with police and EMS.
- **Community Concerns:** Friends and family expressed concern over the lack of police response and the handling of AP’s mental health needs.
- **Digital Evidence:** AP’s cell phone usage supported the timeline for AP’s death.

Under the Criminal Code (Section 219), criminal negligence causing death involves:

“Doing anything or omitting to do anything that it is his duty to do, showing wanton or reckless disregard for the lives or safety of others.”

To meet this threshold, the following must be established:

1. **Legal Duty:** The officer had a duty imposed by law (e.g., responding to a wellness check).
2. **Omission or Act:** The officer failed to act or acted in a way that breached that duty.
3. **Wanton or Reckless Disregard:** The conduct must go beyond mere carelessness—it must show a marked and substantial departure from what a reasonable person would do.
4. **Causation:** The failure must be a contributing cause to the death.

While this investigation raises concerns about police conduct (i.e. failing to conduct a wellness check on person with known mental health issues and a very recent history of a suicide attempt), I have not formulated reasonable and probable grounds to suggest that an offence occurred given that the OCME determined that AP would have been deceased 48–72 hours prior to being discovered. As such, the missed check could not have been a contributing cause to AP’s death.

SIRT-NL will now conclude this file.

Final Report prepared by:

Stephen Ring, Director

Serious Incident Response Team - Newfoundland and Labrador

August 4, 2025

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