

# ***FINAL REPORT: IIU concludes investigation into death while in police custody***

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On April 17, 2019, the Winnipeg Police Service (WPS) notified the Independent Investigation Unit of Manitoba (IIU) of an incident that had occurred the previous evening. The incident concerned a death of a male, while in custody at the District 3 station on Hartford Avenue.

The notification stated (in part):

*On Tuesday, April 16, 2019 during the afternoon, the affected person (AP) allegedly committed two separate assaults on the complainant. Winnipeg Police were called but AP left the complainant's residence prior to their arrival.*

*At 7:14 p.m., members of WPS were actively searching for AP and located him on Main Street at Sutherland Avenue. AP was placed under arrest for the a/m offences and was taken to the District #3 Police Station at 260 Hartford Avenue (District 3). He was placed in Holding Room #1 and processed on these charges.*

*At approximately 10:15 p.m., arresting officer(s) entered the room and found that the accused had hung himself. AP was cut down and first aid was started. Winnipeg Ambulance Service (WAS) was summoned. WAS conveyed AP to Seven Oaks Hospital (7-Oaks) in critical condition. He passed away shortly after.*

As this matter concerned the in-custody death of a person, which may have resulted from the actions of a police officer(s), 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.

Information obtained by IIU investigators included:

- WPS Briefing Report
- WPS Prisoner Injury Report
- WPS Call History files
- prisoner log sheet
- WPS officers' notes, reports and narratives
- FIS photos (folder containing 524 JPEG images)
- 911 Emergency calls
- in-custody death report
- prisoner injury report
- officer and dispatch communications

- WPS Policy on Death or Injury Non-Member/In-Custody Death and Intoxicated Persons
- autopsy, pathology and toxicology reports respecting AP

Due to 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, the civilian director was not prepared to designate a subject officer (SO). A decision whether to designate anyone as SO was deferred until more information could be obtained through this investigation. The civilian director did designate nine WPS officers as witness officers (WO1-9). IIU investigators also interviewed six members of the Winnipeg Fire and Paramedic Service (WFPS) (PW1-6).

**Witness Officers:**

WO1 was working the evening shift at District 3 on April 16. WO1 stated he and his partner, WO3, were involved in the arrest of AP that evening and transported him to District 3. AP was placed into Interview Room 1 and his handcuffs were removed. WO1 stated that the door to Interview Room 1 had a wooden flap that can be flipped up which allowed you to look into the room. Plexiglas and a steel grate on the opening result in a partially obscured view. You cannot see to the floor from this point of view.

AP had stated to WPS officers that he had consumed approximately 10-11 alcoholic beverages throughout the afternoon, but had not taken any drugs. WO1 stated that AP was cooperative throughout the process. WO1 stated that when AP was asked if he had any suicidal thoughts, he laughed. AP stated that he was intoxicated. WO1 stated that this statement required police officers to check on AP every 15 minutes. WO1 completed a Prisoner Injury Report, as AP had a visible scratch on his person that he said was a result of a previous altercation. WO1 stated that a senior WPS officer advised him that AP could be released from custody if a responsible adult was located and if AP could provide an address to reside. WO1 states he made three phone calls to individuals to determine whether AP could be released to any of them. WO1 states that he met with AP after each phone call to advise him of the progress. WO1 states that he did not record the times of the phone calls. WO1 states that in light of the fact that no responsible adult was prepared to assist AP, the senior WPS officer advised that AP would be transferred to the Provincial Remand Centre (PRC). WO1 stated that AP had requested a washroom break, which was granted. WO1 stated that he did not record the time and purpose. At 10:10 p.m., WO1 spoke with AP and advised that he would be transferred to PRC shortly. WO1 stated that AP was awake, calm and appeared fine. WO1 stated that he left AP and was outside, meeting with WO2. Within 10-20 minutes, WO1 stated that WO2 opened the flap on the door to Interview Room 1 and looked in. WO1 stated that WO2 said, "*Your guy looks creepy, he's just standing there.*" WO1 stated that he looked through the flap and into the room. WO1 stated that he saw AP standing in the middle of the room. AP was not doing anything. AP did not have a shirt on but was wearing pants. WO1 stated that he unlocked the door (by moving two deadbolts) and entered the room, followed by WO2. WO1 stated that on entry, he saw AP hanging by his shirt, tied to a grate in the ceiling and around his neck. WO1 stated that he yelled for help and tried to rouse AP. As WO1 wrapped his arms around AP, WO2 cut the shirt. AP was unresponsive as he was taken down. WO1 could not detect a pulse and immediately commenced CPR. WO1 stated that he was told by WO3 that AP's boots were seized as evidence in his criminal matters. WO1 states he made a note entry at 10:00 p.m. as that was the time WO3 told him the boots were seized.

WO2 was working the evening shift at District 3 on April 16. WO2 stated he met and was talking to WO1 as they stood in front of Interview Room 1. Within five minutes, WO2 stated that he asked WO1 who was in custody. WO2 stated that he then lifted up the wooden panel in the door to look in. WO2 stated that he saw AP, who appeared to be standing without a shirt on. WO2 stated that AP's eyes were open; his head was slightly tilted to the right and appeared to be looking towards the cell wall. WO2 stated that he did not see anything around AP's neck. WO2 stated that he asked WO1 if AP had come to District 3 with no shirt on or whether he taken it off in the cell. WO2 stated that WO1 then looked through the door flap. WO2 stated that WO1 immediately called to WO3 and then opened the door to Interview 1. WO2 stated that he and WO1 entered the room. WO2 stated that AP was hanging from a fabric that was tied to the ceiling grate. WO2 stated that WO1 lifted AP up and he cut the fabric that was wrapped around AP's neck.

WO3 was working evenings at District 3 on April 16. WO3 was partnered with WO1 when a call for service regarding a complaint of an assault with weapon was received. AP was identified as the perpetrator of the assault. WO3 stated that AP was located near Main Street and Sutherland Avenue in Winnipeg. AP was arrested without incident and transported to District 3. WO3 stated that AP was intoxicated at the time of his arrest. He was stumbling across Main Street and smelled of alcohol. WO3 stated that they arrived at District 3 at 7:28 p.m. WO3 stated that WO1 searched AP. AP was wearing a yellow shirt and pants when he was placed into Interview Room 1.

WO3 stated that a prisoner log sheet was completed for AP. During this process, WO3 stated that AP was asked if he was suicidal. AP responded that sometimes he is and sometimes he is not. Based on this answer, WO3 recorded his suicide risk as "unknown." A senior WPS officer told WO3 and WO1 that AP could be released to an adult if they could locate someone to release him to. WO3 was aware that WO1 was unsuccessful in locating a responsible adult to turn AP over to and that AP would have to be detained at the PRC. WO3 did not have a discussion with WO1 about the prisoner checks. WO3 started checking on AP shortly after 10:00 p.m. WO3 opened the door to Interview Room 1 and noted that AP was sleeping on the floor. This is the only check that WO3 conducted on AP and it was recorded on the prisoner log sheet. WO3 stated that it was suggested that AP's boots be seized as evidence. WO3 stated that the boots were seized and placed in an evidence bag. WO3 does not know what happened to the boots subsequently. WO3 states recalling someone saying, "*Your prisoner looks weird - he's just standing there with no shirt on*" but does not know who said it. WO3 stated seeing WO1 unlock the door to Interview Room 1 and enter in the company of another officer. As the door opened, the first thing WO3 saw was AP hanging, and, "*he was facing towards the door.*" WO3 stated seeing a yellow shirt tied around AP's neck and to the grate in the ceiling.

WO4 was a Patrol Sergeant on duty during the evening shift at District 3 on April 16. When WO4 returned to District 3 from a call, he heard a male voice say, "*No, he's hanging*" and then sounds of a commotion. WO4 stated that he rushed to Interview Room 1 and noted several WPS officers were dealing with a male, who was laying on the floor. The male was unresponsive and appeared to be unconscious.

WO5 was working the night shift at District 3 on April 16. At one point that evening, WO5 heard someone say "*hanger,*" but he cannot recall the exact words. WO5 recognized that something

was going on, so he went into the hallway leading to the interview rooms. At Interview Room 1, WO5 stated that he saw a yellow shirt tied to the screen in the ceiling.

WO5 stated that any items taken from a prisoner would be stored in a box on the door of the interview room. WO5 could not recall seeing any large items, such as coat or boots, but believes there is a storage area for that kind of item or items are put on the floor outside the room. WO5 does not recall if a hockey game was playing on the television, but believes it was. WO5 stated that a prisoner log form is kept at the Sergeant's desk and completed by the officer(s) who made the arrest. The arresting officers are responsible for a prisoner.

WO6 was working at District 3 as a Street Supervisor during the evening shift on April 16. At 10:00 p.m., WO6 was at the front doors of District 3, waiting for WO4 to arrive. Just after WO4 arrived, WO6 stated that he heard a loud voice stating that a male was hanging. Making his way to Interview Room 1, WO6 stated that he saw yellow material hanging from a two-ft. by two-ft. square grate in the ceiling. The material was threaded through the grate, hanging down, and was of a similar material to that he noted around the male's neck.

WO7 had been at District 3 for approximately 20 minutes when he realized he needed an access card from his police vehicle, parked at the rear of the station. WO7 stated that he was unaware anyone was in the holding room. WO7 stated that as he was walking past the holding rooms, he noted WO1 was opening the door to Interview Room 1. As the door opened, WO7 stated that he saw a male hanging from a grate in the ceiling. WO1 and WO2 had entered the room. WO1 was trying to hold the male up and WO2 was cutting him down.

WO8 was the supervisor on duty at District 3 on April 16. His shift was 3:00 p.m. to 1:00 a.m. His duties as the officer in charge ended at 8:00 p.m. when WO9, the night shift supervisor, arrived on duty. WO8 stated that he recalled WO1 and WO3 bringing AP into custody at District 3. WO8 stated that he directed them to take AP to Interview Room 1. WO8 stated that they wrote the AP's name on a chalkboard, filled out a prisoner log sheet and then spoke with him about the details of the apprehension. WO8 states that the risk assessment on the prisoner log sheet identified AP as a medium suicide risk. WO8 states that this assessment was made by WO3. For this reason, AP was deemed a medium risk, which required regular visual checks every 15 minutes by the arresting officers. WO8 stated that he confirmed AP was intoxicated and had scratches on his person that he said he received in a fight. When WO9 took over as officer in charge at 8:00 p.m., WO8 stated he briefed him in the Sergeant's office. WO8 stated that he then moved to a different workspace, but could not recall what he did on that specific evening. WO8 stated that he informed WO9 that the plan was to release AP to an adult who could take charge of him. However, if no such adult could be located, AP would remain in custody at the PRC or go to the Main Street Project on Martha Street. At some point, between 7:29 p.m. and 10:00 p.m., WO8 stated he spoke to WO3 about AP's offence in the parade room.<sup>1</sup> According to WO8, he was aware that work boots might have been used as a weapon. WO8 stated that he saw AP's boots on the floor and suggested that they be seized as evidence. When it was noted that there is an entry on the property log sheet for these boots going into stores, it had not yet been signed by WO8. WO8 originally stated this occurred at just before 10:00 p.m., and subsequently

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<sup>1</sup> The parade room is the typing room where officers complete their reports

stated he was uncertain if WO9 had taken over when that conversation occurred. It should be noted that the log sheet states that the boots were logged in at 10:00 p.m.

After 10:00 p.m., WO8 stated that he was in the locker room, changing out of his uniform as he had a personal errand to run and his shift did not end until 1:00 a.m. WO8 stated that WO5 entered the locker room and told him that a prisoner had hung himself.

WO9 started his shift at District 3 at 8:00 p.m. on April 16. On his arrival, WO9 took over the duties performed by WO8 that evening. WO9 stated that WO8 informed him that AP was in Interview Room 1. WO9 stated that he had not interacted with AP and gave no direction to the arresting officers. WO9 stated that he was not aware of any concerns related with AP. Shortly after 10:00 p.m., WO9 stated that he heard that AP was hanging and there was an immediate request for an ambulance.

### **WFPS Members:**

During the evening of April 16, PW1 was working as part of a two-man paramedic crew within an ambulance. PW1 stated that they were dispatched to an asphyxiation at District 3. PW1 stated that on arrival, a four-man crew of the fire department was already on scene. Additionally, a medical supervisor and student arrived at the same time. PW1 stated that they set up their stretcher and equipment in that open area. Three firefighters were in the room, doing chest compressions on AP. The paramedics began their medical intervention. PW1 stated that there were no police officers in the room at this time. PW1 stated that an article of clothing was tied to something on the ceiling. AP was transferred to a stretcher and put in the ambulance.

PW2 was working with three other members of WFPS. They were called to attend at District 3 in response to a "99"<sup>2</sup> call. He had no information as to who was in cardiac arrest. On arrival, PW2 stated that all four entered the building through the main public entrance. PW2 asked a series of questions to assist him in determining what treatment to provide to AP. Without treating the underlying cause, they will be unable to treat the cardiac arrest. PW2 stated that he thought the police were not forthcoming with any information. PW2 noticed that the male had ligature marks on his neck. PW2 asked what had happened, at which point police officers pointed to the ceiling and PW2 saw a yellow t-shirt hanging from the ceiling. PW2 stated that he concluded that the man had hung himself.

PW3 was a member of a crew of four firefighters with WFPS. He believes that the call to attend District 3 was a "99." The ambulance and medical supervisor arrived around the same time as PW3's crew. PW3 stated that they were met at the door by two police officers and directed toward a holding cell where the patient was located. The male patient was in cardiac arrest, he was on his back and two police officers were with him. One officer was doing chest compressions.

PW4 was part of a four-man firefighter crew that attended a medic call at the District 3. The call had come in as a "99." PW4 stated that, on arrival, they were directed into a detention room at the police station. A shirtless male was laying in the left corner of the room. The police officers stepped out of the room as the firefighters arrived. PW4 stated that he heard someone say that no one had seen the male for 10 or 15 minutes. PW4 saw ligature marks on the male's neck. He

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<sup>2</sup> An alert of a cardiac arrest

asked what had happened and someone stated that the male had hung himself and that police had cut him down. PW4 looked up and saw a t-shirt in the metal grate vent on the ceiling.

PW5 was in charge and supervised the four-man firefighter crew that responded to the 99 call at District 3 on April 16. When they arrived at District 3, the police directed the fire crew into an interrogation room. Marks were observed on the male's neck and police were asked if he had hung himself. The police confirmed that the male had hung himself from the air vent using his shirt, that they had cut him down and that they worked on him until WFPS arrived. A police officer told the crew that the male had last been seen "*about 15 minutes ago.*"

PW6 is an intermediate care paramedic with the City of Winnipeg and, on April 16, was working with a medical supervisor as part of an apprenticeship program. PW6 stated that he responded to a call for service at District 3. The call was a possible hanging cardiac arrest, meaning no heartbeat and not breathing. On arrival, PW6 states that a police officer was waiting to let them in.

PW6 stated that the patient was in a small concrete cell or a holding area. The police had cut down the patient. The patient had a ligature mark, bruising and abrasions on his neck, which was consistent with the story. PW6 asked how long the patient had been alone in the cell and was told by a police officer that he was alone 10 to 15 minutes before he was discovered hanging.

### **Prisoner Log Sheet:**

The Prisoner Log Sheet documented the checks of AP on April 16 as follows:

- 8:00 p.m. normal/seated
- 8:15 p.m. “
- 8:30 p.m. sleeping
- 8:45 p.m. “
- 10:00 p.m. sleeping

There are no checks documented between 8:45 p.m. and 10:00 p.m., or between 10:00 p.m. and when AP was discovered hanging at approximately 10:30 p.m.

### **Post Mortem Examination:**

The Report of the Medical Examiner was received by the IIU. The cause of death for AP was identified as hanging. A toxicology report prepared by the National Forensic Laboratory Service, determined that AP had 115 mg per cent alcohol in his blood. He also had 264 ng of Diazepam, an anti-anxiety drug and 137 ng of Diphenhydramine, a drug found in over-the-counter sleep aids.

The pathologist who performed the post-mortem related that the ligature mark on AP's neck was fully pronounced because the deceased (AP) was fully suspended. The time of death could have been within 20 minutes of AP's discovery, but it could also have been longer. The pathologist added that AP did not die in a matter of seconds, but probably lingered two to three minutes.

**Conclusion:**

Following the completion and review of this investigation, the following conclusions can be made:

1. AP was lawfully arrested and lawfully detained at District 3.
2. There were several attempts to assist AP in securing his release from custody that were not successful and resulted in the prospect of continued custody at PRC.
3. AP was assessed as a medium risk for suicide and subject to 15-minute checks while in custody at District 3. Unfortunately, there was a breakdown in this process between 8:45 p.m. and 10:00 p.m. and again, between 10:00 p.m. and 10:30 p.m.
4. There are no video recording capabilities at District 3 to monitor holding rooms.
5. It is apparent that AP, and AP alone, is responsible for the suicide he attempted and his resulting death.

This is a tragic set of circumstances and AP's family and friends are left with a great loss. The police clearly had a duty to look after AP while he was in their custody. At the outset, it appears that policy and processes were maintained in the execution of that duty. There is no explanation why the policy and processes were not maintained for the ensuing hour and 45 minutes. AP was checked on at 10:00 p.m., and found to be asleep and alive, while in police custody. It is afterwards, that AP's act to hang himself occurred.

While the level of expected care was closer to the minimal at best, I am unable to find sufficient, or any, evidence to support the contention that any of the police officers actions, or inactions, did anything to transgress the limits of care prescribed by the criminal law in the circumstances of this case. In conclusion, there is no evidence that would justify the designation of any of the police officers as subject officer.

Notwithstanding these finding that no breach of criminal law has occurred, there are aspects of this investigation that should compel further review of operations at District 3:

- the absence of recorded checks on the well being of AP
- the seizure of AP's work boots and apparent discrepancies on timing, place of seizure, and location of exhibits and chain of continuity
- the lack of a proper recording of AP's trip to the washroom
- the circumstances of the preparation and review of the arrest report
- the apparent ease and access to the ceiling grate
- the absence of video recording facilities within District 3
- the absence of electronic recordkeeping of comings and goings through external or internal doors

Manitoba's chief medical examiner has called for an inquest with respect to this death pursuant to The Fatality Inquiries Act. It is hoped that other issues related to this matter will be considered.

Accordingly, this matter is now closed.

**Final report prepared by:**

Zane Tessler, civilian director  
Independent Investigation Unit  
November 25, 2020

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