IIU | INDEPENDENT INVESTIGATION UNIT OF MANITOBA

IN THE MATTER OF AN INVESTIGATION INTO A DEATH WHILE IN POLICE CUSTODY IN CHEMAWAWIN

FINAL REPORT OF THE CIVILIAN DIRECTOR

OF THE INDEPENDENT INVESTIGATION UNIT

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IIU File Number:	2023-0020
Date of Release:	June 14, 2024

Introduction

On March 23, 2023, the Royal Canadian Mounted Police (RCMP) notified the Independent Investigation Unit of Manitoba (IIU) of an incident.

The written notification disclosed the following information:

*"On March 22nd 2023, at 7:40 p.m. civilian witness (CW1) called the Chemawawin RCMP and stated that affected person (AP) was refusing to leave a residence located at * Pon Street. CW1 reported that AP was intoxicated, pushing people around and scaring the children at the residence.*

▪ *At 7:54 p.m., witness officer (WO2) arrived on scene and AP was arrested. At the time of arrest, AP was rousable, had slurred speech and was walking on her own. AP was lodged in a cell at the Chemawawin Detachment.*

▪ *On March 23rd 2023, at 10:01 a.m., WO2 received a phone call from Detachment Services Assistant who stated that the cell guard could not wake-up AP.*

▪ *At 10:08 a.m., WO2 arrived at the detachment and located AP in the cell and was unresponsive. WO2 immediately started CPR on AP.*

▪ *The nurses from the nursing station arrived and pronounced the time of death at 10:43 a.m..*

▪ *The cell is secure and MCU and IDENT have been engaged.*

▪ *NOK was conducted by R.C.M.P. Members as AP's family attended the detachment."*

As this matter concerned a death, the IIU assumed responsibility for this investigation in accordance with Section 65(4) of The Police Services Act (PSA), and IIU investigators were assigned to this investigation.

IIU investigators obtained the following information from RCMP, among other items:

- Police Notes X8
- Computer Automated Dispatch event (CAD) x2
- Occurrence Summaries X3
- Occurrence Reports X2
- Autopsy photos
- Dispatch recording
- Prisoner log sheet and prisoner report
- Scene photos

Due to a dearth of information at the outset about whether any officers were directly or indirectly involved in the cause of the affected person's (AP) death, the civilian director did not designate a subject officer (SO). This decision was later re-evaluated and no subject officers were ever designated.

Scene Examination

An RCMP forensic identification services (FIS) officer attended the scene. An examination was conducted, photographs were obtained, and swabs and exhibits were seized. There was vomit in the toilet and there was an unusual stain on the bench in the area where AP's head had been. Swabs were obtained of both substances.

Facts and Circumstances

Civilian Witnesses

CW1

On March 24, 2023, IIU investigators obtained a statement from CW1, the nephew of AP. On March 22, 2023, he called police as AP was drunk. She was refusing to leave his house and was "disturbing the peace." He stated that AP was also hiding knives and was pushing his grandfather around and yelling at him. He added that there were also two children in the house, who were watching her, but he later went on to say it was just his little sister that was present. He stated that his grandfather is very frail, who is also AP's boyfriend. CW1 advised that two officers came to the house, handcuffed AP, and had AP put on her shoes. CW1 said the officers were not physical with her and she was not physical with them. They then walked her out of the house to the police car.

CW2

On April 17, 2023, IIU investigators met with CW2. CW2 advised that he was working as a cell guard. WO2 had called him to work. He arrived at 8 p.m. and WO2 let him into the building. AP had already been secured in cell 1. WO2 did not provide any information regarding her or her condition. She was the only person in cells, and they were alone together all night. Cell 1 is located beside the desk that CW2 sat at all night. At the desk there is a monitor that allows him to observe AP in the cell. He said that AP slept most of the night; she did move around a bit, but he did not see anything that concerned him. She also woke up approximately four to five times and asked for water and coffee. He did not give her any food or anything else during her time in custody, and she did not ask for anything else. He gave her water in a fresh cup. He also gave her coffee on one occasion.

CW2 said he monitored AP by watching the screen and he could hear her snoring. He added that he did not have any conversations with her and during his limited contact with her he did not get the impression that she was under the influence of anything, but he thought that she had been drinking earlier. AP did not have any issues while she was in cells; she never said she was hungry or in pain or uncomfortable or not feeling well. The only thing she asked for was the heat to be turned up because she was cold. While the heater was on it was more difficult to hear AP. At approximately 9:30 a.m., the heater went off and he didn't hear any snoring, so he went to check on her. He looked through the window and the pass through. He saw that AP was laying on her back on the bench and she was covered with a blanket. When he didn't hear any breathing, he knocked on the door and called her name, but there was no response. He told the woman that

works in the detachment that he needed help. She started work at 9 a.m. He believed she was the only person that he saw in the building, as he did not see any officers come into the station that morning.

The woman called for the officers to attend. Then they waited for the officers to arrive as they cannot open the cell door. He estimated that the officers arrived within five to 10 minutes after they called. The officers opened the cell and checked to see if AP had a pulse. Then they started doing CPR. CW2 said he didn't know what to do so he just sat at the desk and watched what was happening on the monitors. He watched for about 20 minutes; he saw the nurses, a doctor and an ambulance arrive. He then decided to leave and went home.

He said he has not spoken with anyone about what happened. CW2 advised that he knows AP from the community, but he only knows her by name.

CW3

On April 17, 2023, IIU investigators obtained a statement from CW3, the detachment service assistant (DSA). CW3 advised that she got into work at 8:50 a.m. on the morning of March 23, 2023. She was alone in the office and there were no officers working at this time. As she prepared for her day, she checked the monitors to see if there was anyone in cells. The monitor view is typically focused on the cells if someone is in custody. On this date, they were focused on the parking lot, so she assumed that no one was in cells, and she went on with starting her day.

While she was checking her email, she heard the door that gives access to the cell area rattling. This surprised her as she did not think that anyone was on that side of the building. The door is routinely locked and cannot be opened from the cell side. CW3 said she initially opened the window in the door, looked through and saw CW2. He was looking at the monitors. She opened the door and CW2 told her that the person was not responding and pointed to the cell. CW3 looked through the door and saw AP was alone and laying on her back on a mat on the bench that ran along the side of the cell near the toilet. She asked CW2 who she was, and he told her it was AP. She asked how long he had been calling her and he said he thought it had been about 10 minutes. According to CW3, CW2 didn’t know what to do because he has not been a guard for very long and only worked on a casual basis. She told him that she would call WO1, who was the officer on call and the acting supervisor. CW3 advised WO1 that the person in cells was not responding, and WO1 arrived in approximately five minutes.

WO1 went right to the back (cell area), and then told her to call the nursing station and have them send a nurse over. She then called them asking to send a nurse over right away. WO2 arrived at the detachment about four or five minutes after WO1. WO1 asked her if someone was coming, and she said a nurse would be right over. He told her that she should also call the ambulance, which she did. She went back to cells, and she heard a nurse and she saw an officer doing CPR. The paramedics arrived on scene moments later. More nurses attended. Then WO2 came into the office area and told her that AP was gone. CW3 stated that she knew AP from the community but didn’t know her personally. She knew AP’s parents and provided their names

and address. The police notified them in an interview room with two nurses and a mental health worker.

CW3 advised that she did not speak with CW2 about the incident and has never had a conversation with the police officers about what they think happened to AP.

CW3 concluded her statement by saying that WO1 and WO2 are upstanding people. She said they are very respectful of the community and that she enjoys working with them.

Professional Witnesses

PW1

On March 24, 2023, IIU investigators obtained an audio statement from PW1 (nurse). PW1 has worked as a nurse in Easterville for more than 10 years. Just after 10 a.m., one of the clerks from the nursing station ran in and told him that something was happening at the RCMP station, and they needed help. No details were provided. The clerk learned about the problem after receiving a phone call from an RCMP officer, but PW1 did not know who made the call.

He ran across to the detachment and went into the cell area. He saw an officer in a cell on his knees doing CPR on a patient that was supine on the floor, lying on a thin mat. The officer told him that the female had just been found unresponsive. PW1 checked the patient's neck for a pulse and found there was none and there were no spontaneous respirations. He noted that she was still warm to the touch, so he knew they had to continue with resuscitation efforts. He asked the officer, whom he believes was WO2, to continue doing CPR. He ran back to the nursing station to get equipment and assistance. He said that he was only in cells for about 30 seconds before running back. The three other nurses that were working at the nursing station went back over to the detachment with him. Three clerical staff members also attended to the detachment at various times as well. As he got to the detachment, EMS had just arrived as well. There are two paramedics that work in the community. He estimated that it only took him a minute or two to get back to the detachment. The officer was still doing CPR. PW1 checked again for a pulse and respirations. There was nothing, so he placed the pads for the automated external defibrillator (AED). He was able to view the body front and back and he did not see any marks on her body that concerned him, such as ligature marks, bruises or injuries. PW1 believes the patient was only wearing a t-shirt, bra and panties, so he was able to get a good look at most of her body.

He activated the AED, which indicated there was no shockable rhythm, meaning the machine was not detecting a heartbeat. The officer continued doing CPR. A cardiac monitor was then put in place. It showed asystole or a flat line; there was no heartbeat. They started getting ready to assist with respirations and they were putting in an IV line. Other nurses were assisting with this. Once the line was in, they began giving her medication.

PW1 advised that they go through the Advanced Cardiovascular Life Support (ACLS) protocol when they are doing CPR and giving medications. Part of this process is to contact the on-call doctor. He spoke with the doctor and she was updated on what was happening. At the doctor's suggestion, they checked blood sugar and temperature. Both readings were within normal limits. He also checked the patient's medical chart, which had been retrieved from the clinic. PW1

stated that they went through four cycles of ACLS without success, and CPR had been going for at least half an hour. At that point, the doctor pronounced a time of death.

PW1 spoke with the officer to try to determine what happened. He wanted a timeline. The officer told him that at 8 p.m. the previous evening the female had been apprehended for intoxication and disorderly behaviour. He said that she was able to walk into the station and she was talking when she was arrested. She was detained in cells overnight. In the morning, security said he heard her snoring at 9:40 a.m. The officer said prisoners are supposed to be checked on every 15 minutes. There was no information about what happened between 9:40 a.m. and about 10:10 a.m., when the officer arrived and opened the door to find her unresponsive. The officer said she had been lying on the bench and PW1 believes the officer moved her to the floor to do CPR.

PW1 advised that he knew the female, whom he identified as AP.

PW1 provided more details about how everyone was positioned in the cell. He stated that when he arrived AP was positioned with her head to the door and feet to the back wall. While they worked on her, he was positioned along AP's right side, for the most part. PW2 was on AP's left side and PW3 was at the doorway doing respirations. The two paramedics stayed in the hall getting medications ready. The officer eventually moved away after they took over. The other officer was in the building, but not in the cell and he never saw more than two officers.

PW1 added that while he was working on AP he did not detect anything unusual, such as unusual smells. She was still warm and there was no rigidity, so it had not been too long since she had a pulse. PW1 later noticed there was emesis (vomit) in the toilet, but to him it just looked like digested food and it did not concern him. There was also a small amount of stool smeared on the bench, but nothing else in the cell seemed unusual to him.

PW1 also had a conversation with the medical examiner, who asked about marks on AP's face. PW1 advised that he didn't notice any. The family had provided information suggesting that AP had been in a dispute a few days before.

PW2

On March 24, 2023, IIU investigators obtained a statement from PW2 (nurse). PW2 went over to the detachment to assess the situation. PW2 then returned to the nursing station to get help and returned to the detachment with PW1 and PW3. When she arrived, an RCMP officer was doing CPR on a person who was lying on a mattress. The person’s eyes were closed, she looked unresponsive, she was not breathing, and she was a "bit blue." PW2 and PW3 ran back to the nursing station to get more equipment. When they returned, the RCMP officer was still doing CPR. They started an IV and began CPR. PW2 took over the chest compressions from the police officer. PW2 noted that AP was still warm to the touch. AP was wearing a hoodie and they had to cut the sleeves to provide medical assistance. She noted that the female was also "incontinent of urine." She observed emesis in the toilet and feces on the bench.

PW3

On March 24, 2023, IIU investigators obtained a statement from PW3 (nurse). She was advised there was an emergency; she grabbed some equipment and ran to the RCMP detachment. When

she arrived at the cell, she observed a constable doing CPR. She did not know the officer's name, but she described him as the larger nice officer. Another officer was standing outside the door and one of her colleagues was assessing the patient. They started an IV and then she started CPR; however, she noticed that she could not get air into the lungs.

Emergency medical services (EMS) arrived and they we able to get a tube down AP's throat to try and open up the air entry; however, PW3 was still having difficulty bagging her. PW3 used suction to try and clear AP's airway. PW3 noted that it is unusual to not be able to get air into the lungs. She believed that there was some type of blockage or fluid in the airway. Her first thought was that AP had aspirated. PW3 also noticed that AP had a darker substance around her mouth and saw a substance that she described as a white powder residue around AP's nose.

PW3 noted that AP was still warm to the touch, and AP did not have any visible injuries on her body.

PW4

On March 24, 2023, IIU investigators interviewed PW4 (nurse). PW4 advised that she has worked as a nurse in Easterville for six years. She assisted at the RCMP detachment after AP was found unresponsive in cells. She described AP as looking lifeless and unresponsive to anything the nurses were doing, including CPR. PW4 stated that AP did not have any visible marks on her body. PW4 continued to correspond with the doctor and then she handed the phone over to PW1. She stated that when she arrived PW3 was doing CPR and then she thought the cell guard took over compressions. PW4 did not physically touch AP. The other nurses were working on her. PW4 stayed in the hall and got items that the other nurses needed. WO2 was the only officer she recalled seeing in the detachment. She also did not see anything in the detachment or in the cell that seemed out of the ordinary, except for some vomit in the toilet.

Witness Officers

WO1

On June 28, 2023, IIU investigators met with WO1. WO1 has been a member of the RCMP for four years and had been working in Chemawawin (Easterville) for almost two years. WO1 advised that he was working with WO2 on March 22, 2023. They were working overtime on another incident when they received a call regarding an unwanted person (AP) who was at a residence yelling and screaming, pushing people around and scaring kids that were at the house. They attended to the address on Pon Street, CW1's residence. AP does not reside there. They found AP in the entrance of the house. She was visibly intoxicated. WO1 noted that AP was yelling, slurring her words and there was a strong odour of liquor coming from her breath. CW1 was present at the house, and he was with AP's father. They both confirmed that AP was causing problems, and she was not wanted there. WO2 placed her under arrest and they handcuffed her. AP was co-operative and was able to follow direction. They helped AP get shoes on and assisted her as she walked out to their vehicle. He added that she was wobbly, but she could walk on her own. WO2 read her her rights and they transported her to the detachment, which took approximately three minutes. WO1 confirmed that there was no WatchGuard system in their police vehicle; therefore, there was no video of the transport.

At the detachment, she was able to get out of the car and walk into the cell area with the officers. They un-cuffed her and searched her. She remained co-operative with them. She removed her own outer layers of clothing, took a blanket and walked into the cell on her own. WO1 stated that at no time did AP complain of any injuries, and he did not see any injuries on her person. She appeared to be healthy, and her behaviour was normal given the circumstances. Lodging her seemed routine. WO1 stayed at the detachment and monitored AP while WO2 left to locate cell guard CW2. When CW2 arrived at the detachment, they ended their shift and went home for the night.

The following day their shift was scheduled to start at 12 p.m.; however, at 10:01 a.m. WO1 received a call from CW3, their detachment service assistant (DSA). She told him that AP was not responding, and they couldn't wake her up. He called WO2 and went straight to the detachment, which took him about six minutes. When he arrived, to his knowledge only CW2, CW3 and AP were in the detachment. WO1 stated that he recalled having a brief conversation with CW2, but he could not recall what was said. He believes he just asked when the last time he spoke with AP was, but he does not remember the response.

He went into the cell and saw AP laying on her back on the bench by the toilet. He tried to wake her but could not. He checked her neck for a pulse, but he did not find one. He left the cell and told CW3 to call the nursing station to get medical personnel to come over. He returned and checked for a pulse again. When there was none, he started CPR. He also tried to look in her mouth for any obstructions but didn't see anything nor anything unusual. WO2 arrived and they continued working on AP until the nurses arrived. At some point, they moved AP to the floor as there was more room to work on her. When the nurses arrived, they took over but he and WO2 continued to help where they could by continuing to do chest compressions. One of the nurses called the time of death at 10:43 a.m. The officers then notified their supervisors. They notified AP's parents at the detachment with several nurses present.

WO2

On June 28, 2023, IIU investigators obtained a statement from WO2. WO2 has been a member of the RCMP for two and a half years, and Chemawawin was his first posting. He was working with WO1 on March 22, 2023. They were on overtime on another matter when they became aware of a 911 hang up which turned into a disturbance incident. They were the only officers working. Police assistance was required at CW1's residence. AP's father opened the door to let them in. He noted that AP, CW1, and AP's father were inside the residence; he could not recall anyone else being present at that time. CW1 advised he had made both 911 calls as AP was intoxicated and causing a disturbance. It was determined that CW1's grandfather no longer wanted AP in the house and AP was advised that she was under arrest. AP did not resist the officers in anyway. WO2 said he knows AP because he has dealt with her several times in the past. AP was handcuffed behind her back and was crying and upset but she did not resist. They walked her to the car with no issues and she was able to walk on her own. Once she was secured in the vehicle WO2 went back to the house to speak with CW1's grandfather to obtain further information. When he returned to the police car, he read AP her rights but she did not answer his questions. WO2 said she just kept yelling about drugs or alcohol in the house and made reference to a safe. They transported her to the detachment, minutes away. AP was able to get out of the vehicle and walk into the detachment without issue. In the detachment, AP was talking. Though

she was slurring her words, WO2 understood what she was saying. She continued to talk about drugs, bottles and a safe. AP was upset about being arrested because she claimed that AP's grandfather was hiding drugs in the house, so he should be arrested. AP was searched and she walked into the cell on her own. The intension was to release her in the morning when she was sober. WO2 also told her he would talk to her about the drugs when she was sober. WO2 said that AP was certainly impaired by alcohol, but he could not say if she had also been using drugs.

WO2 could not recall how they got a hold of the cell guard, but he recalls that they had a guard take over.

The following day their shift should have started at noon however he received a call from WO1 in the morning. WO1 advised that the DSA had called him saying that AP was unresponsive. WO1 told him he was going to the detachment right away, he would walk over because he would get there faster, and it would only take him a minute. WO2 stated that he was very aware that there was an issue at the detachment, and he had to get there right away.

When WO2 got to the detachment WO1 was already there. WO1 confirmed that AP was unresponsive. WO2 went into the cell and saw AP laying on the bench. She was on her back with her head toward the toilet and she looked pale. They again tried to get a response from her, but there was nothing. They put her on the floor and began resuscitative procedures. He recalled that he felt her neck to see if she had a pulse but there was none, so they kept doing chest compressions. At one point, he left to move the police car out of the way because he wanted the ambulance to be able to back into that area.

Nursing staff began to arrive, and PW1 was the first nurse on scene. A few more nurses arrived; EMS also attended; there were two paramedics. WO2 said there were a lot of people tending to AP. For approximately 42 minutes, everyone was working to assist her. WO2 advised that he and WO1 helped by doing chest compressions. Their efforts were ultimately unsuccessful, and AP was pronounced at 10:43 a.m.

While he was in the cell, he noticed that there was a substance on the bench in the location where AP's head had been. He was not sure what it was, but it looked like it could be vomit. He could not recall seeing anything else that was unusual in the cell.

WO2 advised that while AP was in his presence she never fell or was hurt in any way. AP also never complained about any injuries or illness. WO2 advised that there was nothing of concern that would cause him to take her to the nursing station. He added that he has dealt with AP while she was intoxicated before and nothing seemed out of the ordinary.

WO2 added that AP had made a complaint with the RCMP on October 21, 2023, the day before she was arrested. She claimed that she had been assaulted the previous day (October 20, 2023). They had attempted to locate her and speak with her regarding this matter, but they could not find her. The first time they saw her after she called police was when she was arrested. WO2 stated that he did not see any visible injuries on her that would make him think medical attention was necessary. She had no obvious wounds or bruises, and she did not complain about any injuries.

Summary of Other Evidence

Detachment and Cell Video

AP is seen getting out of the police vehicle and walking into the RCMP detachment. She appears to have no difficulty walking on her own and the officers are simply guiding her. She enters the detachment at approximately 8:10 p.m. on March 22 and once in the station the officers remove the handcuffs, and she removes her outer layer of clothing. She is upset and crying and appears to be speaking with the officers. She walks into the cell. She was alone in the cell throughout her time in custody.

The next morning at 9:03 a.m. she appears to be sleeping on her back on the side bench when she displays a series of spastic movements and appears to be gasping for air. By 9:08 a.m., all movement has stopped.

At 9:59 a.m., CW2 seems to become aware that there is an issue with AP. At 10:11 a.m., WO1 enters the cell to assist her.

The video corroborates all of the information provided by the officers and the civilian witnesses.

Prisoner Logbooks

Notations were made in the log every 15 minutes between 12:15 a.m. and 9:45 a.m., which consistently documented AP as sleeping or laying on the bench. At 10 a.m., it is noted that CW2 is off duty. No other notations were made.

Prisoner Report

Completed when AP was lodged. The points of interest were noted: highly intoxicated, starting fights, unwanted at residence, charged with mischief and lodged; alcohol – recent; balance – wobbling; speech – slurred; consciousness – alert; injuries – none observed.

Toxicology Report

Results showed that AP's ethanol was between 0.50 g/l and 0.65 g/l, and she had trace amounts of cocaine in her system. The report further indicted that alcohol in this range may produce the following effects: increased self-confidence and talkativeness, mild euphoria, reduced co-ordination and slightly slowed reactions.

Medical Examiner and Autopsy Report

The report of the medical examiner dated February 7, 2024, indicates that the cause of death is noted as *cocaine toxicity* and that *cardiomegaly is as a significant condition contributing to her death.*

The autopsy report dated January 24, 2024, indicates that AP had minor blunt force injuries on her face and extremities; however, these injuries did not cause or contribute to her death. AP had mild cardiomegaly (an enlarged heart), a condition that is most often caused by hypertension but is also associated with the chronic use of certain drugs such cocaine and alcohol. This condition increases the risk of an abnormal heart rhythm or heart attack.

The pathologist indicated that she observed on the cell video that AP showed sudden, irregular non-rhythmic thrashing of her upper and lower extremities. She added that these movements were possibly in keeping with seizure activity. Shortly after, these irregular, potentially seizure-type movements occurred and AP became unresponsive, progressing from visibly apneic breaths to no visible chest wall movement. She noted that AP had no history of seizure disorder; however, many abnormalities, including electrolyte abnormalities, can trigger a seizure without there being an underlying seizure disorder. Testing of the vitreous fluid was done, and it did not reveal evidence of ketoacidosis.

There was co-ingestion of cocaine and ethanol at some point prior to death. Toxicological testing of the vitreous fluid detected ethanol (0.65 g/l). Death is typically not associated with the concentration of ethanol detected in this case.

A trace amount of cocaine and a low concentration of its metabolite, benzoylecgonine, were detected, indicating that cocaine was consumed at some point prior to death. Cocaine at any concentration can cause spasm of the coronary arteries, which can precipitate cardiac ischemia and/or fatal arrythmia, both of which can result in death.

Conclusion

The IIU's mandate is to consider whether AP's death may have resulted from the actions or inactions of the police officers. Following due consideration of all the circumstances of this matter and a careful, thorough review of all evidence obtained in this investigation, I am satisfied that the police officers did not contribute to the death of AP.

This is truly a tragic set of circumstances. AP was arrested without incident. She was able to walk on her own. She entered the detachment cell at approximately 8:10 p.m. on March 22. After being lodged, the police contacted a jail guard to come into work that evening while AP was detained in cells. AP asked for water and coffee during her detention and the jail guard (who is not under the IIU's mandate) provided her with same. There was no evidence that she had any injuries that required medical attention prior to being lodged in cells. WO1 stated AP was co-operative and at no time did she complain of any injuries, nor did he see any injuries on her person. She appeared to be healthy, and her behaviour was normal given the circumstances. WO1 stated that lodging her seemed routine. The detachment videos corroborate this evidence. The evidence demonstrates that the police and nursing staff took all necessary measures. Sadly, the AP died the next morning; the cause of death being cocaine toxicity and cardiomegaly as a contributing cause.

Therefore, no charges are recommended against the witness officers, and the IIU investigation is now completed and closed.