SiRT | SERIOUS INCIDENT RESPONSE TEAM

Summary of Investigation

SiRT File # 2023-061

Referral from

Halifax Regional Police

December 14, 2023

Erin E. Nauss
Director
May 13, 2024

TRIGGER WARNING

This summary contains content about suicide. Suicide is a complex public health and safety issue. If you or someone you know is in immediate danger, call the Provincial Mental Health Crisis Line toll-free at 1-888-429-8167 or call 911. For less urgent situations, support for mental health, addiction and wellbeing is available for children, youth and adults, and information can be found at: https://novascotia.ca/mental-health-and-wellbeing/

MANDATE OF THE SiRT

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

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

INTRODUCTION

On December 14, 2023, the SiRT received a referral from the Halifax Regional Police ("HRP") regarding an incident that had occurred in the HRP Prisoner Care Facility. The Affected Party ("AP") was housed in cells on December 14, 2023, and went into medical distress after tying his shirt around his neck and the cell bars in an attempt to end his life. EHS attended and transported the AP to hospital. He passed away on December 15, 2023, after cessation of medical intervention. In this matter, two officers were identified as Subject Officers ("SO"s) as they were responsible for the HRP Prisoner Care Facility. Subject Officer #1 ("SO1") is a Sergeant with HRP, and Subject Officer #2 ("SO2") is a Special Constable. In accordance with the Serious Incident Response Team Regulations made under the *Police Act*, the SiRT has jurisdiction to investigate police officers as well as special constables while employed by police working in a lock-up facility such as the HRP Prisoner Care Facility. The SiRT concluded its investigation on April 15, 2024.

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

1. Civilian Witness Statement (1)
2. Witness Officer Statements and Notes (18)
3. Video Recordings from Prisoner Care Facility and Cell
4. Police Radio Transmissions
5. 911 call
6. Photographs of HRP Prisoner Care Facility and Cells
7. Final Postmortem Report and Toxicology Report
8. HRP Policies
9. Department of Justice Review

INCIDENT SUMMARY

Originating Incident

On December 13, 2023, at 11:46 PM, the Halifax Regional Police were dispatched to a residence regarding a weapons call. The AP was alleged to have broken into the home of a person known to him and committed an assault with a weapon.

Civilian Witness #1 ("CW1") called 911 and indicated that the AP entered his home and attacked him with a large metal pipe, causing injuries to his leg, and that the AP was no longer on scene. In his statement following the incident, CW1 indicated he was home alone in bed, when he saw the AP turning on the lights and holding a large metal pipe. The AP swung the pipe, hitting CW1 in the leg. CW1 advised that the incident was brief, and the AP ran from the residence.

Witness Officers #1 and #2 ("WO1" & "WO2") were dispatched to the residence. They observed a mark on CW1's leg and observed items knocked over in the home.

Witness Officers #3 and #4 ("WO3" & "WO4") were dispatched to the area and tasked with locating the AP. They located his address and phone number and contacted him by phone. The AP advised that he was at his home. Police arrived and told the AP that he was going to be placed under arrest. The AP invited the officers into his house. They noted the smell of alcohol on his breath and that he appeared emotional. There were no other obvious signs of intoxication. He stated he had ongoing issues with CW1, and he had planned to take action and tell CW1 he wasn't going to take it anymore. The AP was provided the applicable legal cautions and was arrested and placed in handcuffs. WO3 stated that he initially told the AP that he would likely be released that evening on an undertaking, however during transport WO3 and WO4 received further details of the incident from the other officers and a decision was made to hold the AP overnight to be brought before a judge in the morning. The AP was advised of this decision during transport and his attitude changed from cooperative to apologetic to "you guys lied to me". He became upset and acted belligerent.

WO4 noted the decision to hold the AP until court in the morning was based on the totality of the charges, the fact there was a weapon and that he broke into the home. The officers also considered the relationship between the AP and CW1 and the distance between their houses.

Arrival at Prisoner Care Facility

The AP's time at the Prisoner Care Facility (PCF) was captured on CCTV footage. This video footage was provided as part of the investigation and documents the officers' and AP's actions. Additionally, the Witness Officer's notes were turned over as part of the investigation and outlined

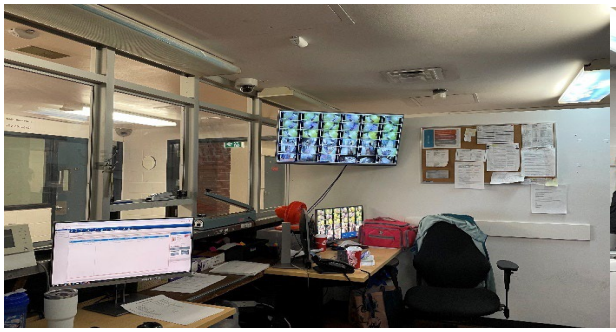
officer involvement with the AP while they were present. As was their legal right, the SOs did not provide their notes, reports, or take part in an interview with the SiRT.

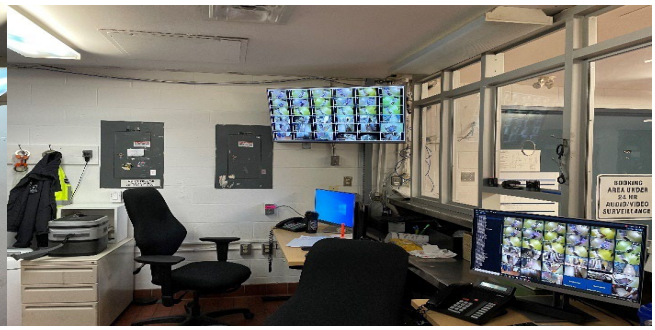
At 12:24 am, WO3 and WO4 arrived at the PCF with the AP. He was cooperative upon arrival. The officers explained that he would be held in cells until the morning and had discussions about whether he would call a lawyer. WO3 and WO4 assisted with preparing the AP to be lodged into cells. This included a search of the AP, completing medical questionnaires, and fingerprinting. Subject Officer 1 ("SO1") and Subject Officer 2 ("SO2") were present during this time. During the search of the AP, it was noted that he was wearing two sets of pants. WO3 removed the first pair of pants and informed him that the string from his second pair of pants would need to be cut. The AP stated "I'm not going to hang myself man, I love myself. I love my life, are you kidding me". The AP also removed a necklace.

At 12:28 am, WO4 competed a Medical Health Transport Form and an HRP Prisoner Care Medical Form. There was nothing on the medical form that indicated the AP was at risk for self-harm. The AP was then taken into the fingerprinting room. The AP was having a conversation with SO2 and was speaking in a positive manner. When the AP returned to the lobby, an officer cut the string on his pants. SO1 was present at this time and told the AP he would attend court in the morning. The AP became upset and said he can't trust the officers. WO4 apologized, the AP accepted the apology and was escorted to his cell. The AP was placed in a cell at 12:42 am and started a discussion with another prisoner in a different cell.

Once the AP was placed in cells, the witness officers left the PCF. WO4 stated that when he left the PCF, he had no concerns for the AP's safety and was of the opinion, considering the events of the evening, that it would be safer for him to stay in cells than return home. WO3 stated that during his interaction with the AP there was nothing indicating he was thinking of suicide.

SO1 returned to the office area where SO2 was situated. The office area has desks and computers for each officer and a computer monitoring system. The monitoring system monitors thirty-six (36) cameras in the facility, which are all on the same screen. Officers do not see or hear what is taking place in each cell individually.





Time from AP being lodged into cells until Cell Check #1

At 12:50 am, SO1 stated he was going to wash his hands and step outside. He remained outside until 12:57 am and returned directly to the office. During this time, SO2 remained at her desk in the office with the surveillance monitors. She worked on the computer, used her phone, and appeared to look up at the cameras. When SO1 returned, he had a conversation with SO2 and then looked at his cell phone and the surveillance monitors. At 12:59 am, SO2 looked at the cameras again and then left to do a cell check. At 1:00 am, SO2 entered the cell area and had a discussion with another prisoner. The cell check lasted about 1 minute and SO2 returned to the office and immediately went to the computer screen. It is possible that she was doing the cell check entry. A cell check timer was then reset.

The movements of the AP during this time were on the cell block recording. Review of video shows that prior to the cell check, the AP was talking to the other prisoners, recited the Lord's Prayer, and stated "I can't believe I am here". The details of conversations were not likely heard by the officers.

Time between Cell Check #1 and Cell Check #2

Between cell check #1 and cell check #2, the AP removed his shirt and tied it around his neck and the cell bars. At 1:04 am, the AP removed his sweatshirt and black long sleeve undershirt, and then re-dressed himself with his sweatshirt. The AP then tried to attach the shirt to a fixture in cells. He made other similar movements at 1:06 am., 1:07 am, and 1:08 am. He repositioned himself at approximately 1:09 am. At 1:10 am his body went completely limp.

Video shows that after cell check #1 (approximately 1:01 am), SO1 remained in the office. SO1 looked at his phone, computer and communicated with SO2. SO2 was briefly out of the office area and when she returned, she spoke with SO1 and looked at her phone. She appeared to look at the camera monitors at 1:09 am and 1:11 am. She looked again at 1:16 am, which is when she noticed activity in the AP's cell and said, "what is that guy doing?". SO1 said he would go check. At the same time, the 15-minute cell-check timer went off.

Both SO1 and SO2 immediately left the office and went to the AP's cell. At 1:17 am, SO1 unlocked the cell door and requested Emergency Health Services ("EHS"). SO2 cut down the shirt. SO1 started chest compressions and the defibrillator was requested. EHS arrived at 1:26 am and at 1:38 am they were able to find a pulse on the AP. EHS departed with the AP at 1:42 am.

Arrival at Hospital and Autopsy Report

The AP was transported to hospital. He remained in critical condition until December 15, 2023, when medical intervention was ceased and he died shortly thereafter.

An autopsy was performed on December 18, 2023, and the cause of death was deemed to be "Hypoxic-Ischemic Encephalopathy due to hanging". A Toxicology Report was also completed, which showed there was a presence of several substances, but there was nothing notable about their levels.

RELEVANT POLICIES

HRP have Prisoner Care Facility Policies that outline procedures for booking and cell checks. These policies include the removal of items prior to a person being lodged into cells and state that the Booking Officer shall monitor all prisoners to ensure safekeeping. The monitoring includes a personal check in the detention area every fifteen (15) minutes, and that the reliance on camera monitors is not adequate. Additionally, if a prisoner is identified as thinking of suicide, more frequent checks are required.

As part of the investigation, a Lockup Inspector with the Department of Justice indicated that HRP has developed a best practice of having a person at the level of Sargeant assigned to the Prisoner Care Facility. It was confirmed that physical checks are required to be conducted every fifteen (15) minutes to check for "signs of life". If a person in custody is thinking of suicide, there is a requirement to have continuous checks throughout their stay.

RELEVANT LEGISLATION

Criminal Code:

Duty of persons to provide necessaries
215 (1) Every one is under a legal duty
(a) as a parent, foster parent, guardian or head of a family, to provide necessaries of life for a child under the age of sixteen years;
(b) to provide necessaries of life to their spouse or common-law partner; and
(c) to provide necessaries of life to a person under his charge if that person

> **(i)** is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and
> **(ii)** is unable to provide himself with necessaries of life.

Offence
(2) Every person commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse to perform that duty, if
(a) with respect to a duty imposed by paragraph (1)(a) or (b),

> **(i)** the person to whom the duty is owed is in destitute or necessitous circumstances, or

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

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

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

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

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

LEGAL ISSUES & ANALYSIS

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

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

At the time of the incident, the AP was lawfully in custody. It was clear that the AP was upset by being held overnight and his ongoing issues. However, no officer observed any behaviour of the AP that led them to believe he would inflict self-harm. The Witness Officers had conversations with the AP, the Subject Officers interacted with the AP prior to him being lodged into cells, and WO4 completed a medical form with the AP, which specifically addressed suicidal ideation and self-harm behaviours. There was nothing from these interactions or the medical form that indicated the AP was at risk. It was clear from comments the AP made to the officers that he was upset about his relationship with CW1. He indicated having a broken heart and needing a hug. According to the officers who initially dealt with the AP they saw him as being emotional and tired but did not observe any signs of self-harm or suicidal ideation.

Prior to the AP being lodged into cells, officers had taken all reasonable steps to remove any items that would potentially cause harm or assist the AP in any form of self-harm. The officers removed his outer pair of pants, cut off the string on his second pair of pants, and removed his necklace. It is important to note that when the officers were removing the string from his pants the AP stated he would not hurt himself because he loved his life.

HRP has policies that outline their procedures for booking and cell checks. These policies include the removal of items prior to a person being lodged into cells and state that the Booking Officer shall monitor all prisoners to ensure safekeeping. The monitoring includes a personal check in the detention area every fifteen (15) minutes, and the policy indicates that the reliance on camera monitors is not adequate. Additionally, if a prisoner is identified as thinking of suicide, more frequent checks are required. Based on the information provided by the Witness Officers and operations of the AP and SOs interactions, it was not reasonable for the officers to think that the AP was thinking of suicide.

In this case, it is clear from video evidence that the SOs followed policy. While merely following policy is not a defence for criminal conduct, it can assist in determining what a reasonably prudent person would do in similar circumstances. A review the policies, the behaviour of the AP, and the actions of the SOs leads me to conclude that a reasonable person in their position would have acted similarly. There were no indications that the AP was at risk to self-harm, the officers properly removed personal items that had the potential to cause self-harm (which included the string in pants and necklace), and they conducted physical cell checks every fifteen minutes. Furthermore, the office housing the camera monitors had an officer in the room at all times between the cell checks. Although the officers were not always watching the video footage, I cannot conclude that this is a marked and substantial departure from what a reasonably prudent person would do in the circumstances.

Once the officers noticed the AP was in distress, they immediately responded to the cell and called EHS. Chest compressions were started, and a defibrillator was requested. EHS was on scene nine

(9) minutes after the officers arrived at the AP's cell. As previously mentioned, there was no indication that the AP was thinking of suicide or at risk for self-harm, therefore it was not reasonable for the SOs to seek medical attention any earlier.

The actions of the SOs fell within the expected behaviour of a police officer. For the above noted reasons, I cannot find there was a substantial and marked departure from what a reasonable person would do in the circumstances. Further I cannot find that the actions or omission of actions showed a wanton or reckless disregard for the life and safety of the AP.

CONCLUSION

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