OPCC File No. 2021-19627
August 21, 2024

IN THE MATTER OF THE POLICE ACT, R.S.B.C 1996 c. 367

AND

IN THE MATTER OF A REVIEW OF ALLEGATIONS OF MISCONDUCT AGAINST CERTAIN OFFICER OF THE VANCOUVER POLICE DEPARTMENT

NOTICE OF ADJUDICATOR'S DECISION PURSUANT TO SECTION 117(7) POLICE ACT

ADJUDICATOR BRENT G. HOY APPOINTED RETIRED JUDGE SECTION 117(4)

AND

NOTIFICATION OF NEXT STEPS

TO: Constable [redacted] (Cst. [redacted])
c/o Vancouver Police Department
Professional Standards Department (the "member")

AND TO: Sergeant [redacted]
c/o Metro Vancouver Transit Police (Investigator)

AND TO: Inspector [redacted]
c/o Vancouver Police Department

Professional Standards Department

AND TO: Mr. Frank Chong
Chair, c/o Vancouver Police Board

AND TO: Mr. Prabhu Rajan
Police Complaint Commissioner (Commissioner)

DECISION SUMMARY

1. This is a review of whether the member had neglected his duty to ensure the well-being of the affected person who appeared intoxicated and later died while in police detention on [redacted].

2. Pursuant to Section 117(4) of the Police Act issued on July 16, 2024 by the Police Complaint Commissioner, I was appointed as Adjudicator concerning allegations of misconduct by Constable [redacted]

3. As part of the historical genesis of this matter the mandatory section 89 investigation pursuant to the Police Act was suspended until the Independent Investigation Office of BC (IIO) completed their review. No criminal charges were recommended. At its conclusion the OPCC resumed its duties on September 1, 2023. Sergeant [redacted] of the Metro Vancouver Transit Police was the Investigator for the Final Investigation Report (FIR) and submitted his Report to Inspector [redacted] (Discipline Authority). She identified one allegation of Neglect of Duty pursuant to section 77(3)(m)(ii) which she found was unsubstantiated.

4. The Commissioner was of the view this was incorrect.

5. I am required to list and describe each allegation of misconduct that may arise after my review of the incident as contained in the FIR and its evidence and documents without influence from any determinations made by others and come

to my own conclusions as to whether or not there appears to be sufficient evidence to substantiate the allegations of potential misconduct.

6. Upon my review of the Final Investigation Report and its' evidence and records, I have identified 1 Allegation of Misconduct which appears to constitute misconduct contrary to section 77(3)(m)(ii):

> "Neglect of duty" in neglecting, without good or sufficient cause, to promptly and diligently ensure the well-being and protection of the affected person with appropriate medical assistance.

7. Next Steps are set out at the end of this decision.

THE LAW ON SECTION 117 REVIEWS

8. Guidance as to how a Section 117 review is considered can be found in Justice Affleck's decision of *Scott v. British Columbia (The Police Complaint Commissioner)*, 2016 BCSC 1970. The question of determining whether the evidence "appears sufficient to substantiate misconduct" is to do no more than express a preliminary view based on the final investigative report as to whether there appears to be sufficient evidence to establish misconduct. An analysis of a particular misconduct with "conclusory language" runs the risk of predetermining the issues. These questions should properly be resolved at the disciplinary hearing. To do otherwise would be adverse to questions of fairness and "invite criticisms of bias" without having had the process of a fulsome disciplinary hearing with a retired judge who has an open mind free from any final predeterminations upon the evidence.

9. In the decision of Adjudicator Baird-Ellan from OPCC file no, 2022-22748 these words are also noteworthy:

> *(57) The review is therefore an assessment of the evidence that falls somewhere between "apparent" misconduct and "proven" misconduct; specifically, whether the evidence "appears sufficient to substantiate" misconduct. While that test may entail some weighing or assessment of the evidence, in particular where there are conflicts, the analysis should not contain any assumptions that the evidence will be interpreted a certain way*

at a discipline proceeding, where the discipline authority may have the benefit of evidence or submissions on behalf of the member.

(*58) The confusion created by the wording of Section 117(8)(d)(i) has been the subject of judicial comment in the past(1), and I will observe here that while there is no onus on the member, the preliminary conclusion required by the section about the "apparent sufficiency" of the evidence is open to challenge at a discipline proceeding in whatever fashion the member may see fit to challenge it, and the discipline authority, despite being the person who has found the evidence apparently sufficient, must approach the discipline proceeding with an open mind about the outcome.*

(1) Scott v British Columbia (The Police Complaint Commissioner) 2016 BCSC 1970 https://canlii.ca/t/gvcbr, para 39.

10. Thus, unless the finding is unsubstantiated, I firmly keep in mind the limitations this review. That it is only a preliminary assessment of the allegations such that they appear sufficient to substantiate misconduct and am mindful that final findings of facts and rulings of law are reserved for the evidence and legal submissions presented, weighed and evaluated at a discipline proceeding for the purposes of the s. 125(b) decision.

SUMMARY OF THE FINAL INVESTIGATIVE REPORT

11. A multitude of persons were interviewed by the IIO. These statements and videos were considered and adopted by the Investigator plus additional statements and other materials. I have in my review likewise reviewed the entirety of the contents of the FIR. As considered by the Investigator I likewise have identified whether Cst [redacted] conduct amounts to Neglect of Duty, section 77(3)(m)(ii) of the Act, "neglecting without good and sufficient cause to promptly and diligently do anything that it is one's duty as a member to do."

12. The deceased, [redacted] was [redacted] years old and had resided at [redacted], Vancouver. She had called 911.

13. **0742 am call to 911**. The substance of this call relates to her suicidal thoughts. She tells the operator her sister had just died. She had thoughts about

jumping off the Cambie Bridge. In the course of the 911 call she noted she had once been addicted to drugs and was now an alcoholic.

14. **0748 am officers dispatched**. Cst [redacted] attended with Cst [redacted] his recruit. At the time of the dispatch they were within 30 seconds of the address. It was a wellness check to determine whether the Mental Health Act should be implemented. They had also been informed there was an outstanding endorsed warrant.

15. On arrival they met [redacted], a support worker for the SRO. She escorted the officers to the affected person's suite whom she had known for the past 1.5 years. She was aware the affected person was an alcoholic and had a past history of drug use. She observed the affected person did not appear intoxicated and was happy. At one point the officer raised the topic of her being suicidal and jumping off a bridge, but the witness noted the affected person laughed at the comment. She also observed that the officer treated her kindly.

16. From Cst [redacted] interview with Sgt [redacted] on February 21, 2024 he observed the affected person to be articulate – that she seemed "very with it." She commented upon her remarks about jumping off the bridge and stated she did so "out of frustration" as she was depressed. Her room was noted to be clean and tidy. Their conversation and interaction was amiable. There was no difficulty in communication.

17. Cst [redacted] statement with the IIO was done on June 2, 2021. He relates that the affected person said she had been drinking all night. Cst [redacted] believed she stated it was vodka, but the amount was unknown. This officer did not recall seeing any alcohol bottles or drugs. He was unable to smell any alcohol noting he was however wearing a mask. She did not appear intoxicated. There was no slurred speech. Nothing untoward was observed about her balance as she walked down a few flights of stairs. She relates she was feeling down as she had lost some close family and friends recently. At the police vehicle she had been placed in handcuffs to the front of her body. These were later loosened for her comfort and then removed as she was escorted into 2120 Cambie for fingerprinting.

18. Cst [redacted] who was also present in her suite and noted her to drink some juice which she smelt but no alcohol was detected.

19. **0815 am arrest for outstanding warrant**. Cst [redacted] determined she was not going to be arrested pursuant to the Mental Health Act but that the outstanding endorsed warrant was to be executed. She had missed a court appearance date. His intent was to have her released and to expedite this process they transported her to the Cambie Street station for fingerprinting. From his experience the release process was quicker at that location rather than the Cordova Street Jail.

20. From the CCTV of the [redacted] residence she is seen walking with confidence through the main hallway. There were no issues with gait or any other mobility difficulties. She is not handcuffed. In the stairwell she is observed holding onto the rail with both hands. From another CCTV she is seen descending a different stairwell holding onto the right railing. Her balance was sure and no difficulties were observed in her mobility.

21. **0820 departure from** [redacted]. Enroute to the Cambie Street office Cst [redacted] observed the affected person was snoring and mumbling, "like talking in her sleep. "

22. **0835 am arrival at VPD 2120 Cambie Street**. From the IIO interview June 2, 2021, Cst [redacted] observed she needed to be awoken from her sleep and required help getting out of the police vehicle. She was not standing up and had slurred speech. He recalls Cst [redacted] asking her if she had taken any drugs or alcohol which she responded negatively. She required the assistance of the officers as they took her by her armpits and helped her up the steps into the building. Cst [redacted] comments "she appeared to be fine, but just like a drunk person."

23. From Cst [redacted] interview with Sergeant [redacted] on February 21, 2024 he observed she had become lethargic and less coherent. She required assistance getting into the building. He asked her if she had taken drugs or was on medication or anything else which he should be alert to medically to which she responded negatively. He knew she had been drinking but was not aware of the quantity. He also knew she was a recovering alcoholic. It was his thought she was either tired or intoxicated from a night of drinking or a combination of both.

24. There was a thought expressed by Cst [redacted] that if she acknowledged taking something he would have considered EHS or taking her to the hospital. He also

noted by his previous experience having worked in the Jail for 6 months and as a wagon driver taking intoxicated persons to the Jail, given there are nurses on staff 24 hours per day, she would be seen by a jail nurse in cells and checked quicker than if a call was made to EHS. These specific words are noted from his interview at Line 99 – 109:

> *Um, going back to at 2120, when, when I was making that assessment um, you know, I knew, had there been something that would've, she would've admitted to would've obviously been making choices of either calling EHS or, or figuring out if our, you know, sergeant approval to transport her to the hospital, but I also know from the jail um, working at the jail for about 6 months prior to , prior to being hired, and then just from my experience working as a wagon driver and bringing people that are intoxicated and stuff into the jail, that they have a nurse on staff 24 hours a day. Um, that nurse will come out and, specifically with people who show signs of intoxication, will make an assessment. Um, I knew that that would be a timely thing and that that would um, the nurse who has better medical knowledge than myself would have any concerns, they would've called for an ambulance and, and would've made sure that that transport would've been done uh pretty quickly. So um, but yeah, we … When we were at the jail we handed her off to the jail staff and she got wheeled in, in a wheelchair, and that was, that was it.*

23. The CCTV images from the Cambie Street VPD Office, shows her requiring some assistance of both officers as she ascends the steps. The officers are observed lightly supporting each side of her as she appears unsteady on her feet and required some assistance in balance. She then walks into the lobby unsupported but was slightly unsteady and takes a seat. One can observe some conversation occurring between the affected person and Cst [redacted]

24. They were unable to complete the fingerprinting process and release as it was a Saturday and the fingerprinting desk was closed. It was decided to transport her to VPD Cordova Jail for that purpose. In explaining this to her Cst [redacted] observes she sat slouched in a chair and responded with "mmm" and nodding. When asked to stand she required help. While descending the steps the officers held her arms. Enroute to the jail she again fell asleep and was snoring.

25. **0850 am arrival at VPD Jail E Cordova St sally port**. Cst [redacted] had used a pressure point to awaken the affected person. Cst [redacted] noted that upon arrival at the sally port her condition had worsened. She was unable to manage steps or walk under her own power. She was placed up against a wall in the administrative area and was held up until a wheelchair was obtained. There was confusion expressed over her change from a sober to intoxicated state. By Cst [redacted] statement he relates that Cst [redacted] said to him that the jail nurse should check her for detention or hospitalization noting that this was the jail staff process.

26. From Cst [redacted] interview he noted that in other circumstances she would normally be placed in the pre-hold upon arrival at the jail but due to her condition he decided to liaise with jail staff to bring her straight in for a search and processing which was accommodated. These words are noted from his interview at line 308 – 320:

> *Sgt [redacted] Mmhmmm … and did you … I mean this is quite a while ago, but do you recall any sort of conversation or verbal dialogue you had with the jail staff who came out to assist you about her or the reason she was there?*
>
> *Cst [redacted] I just said sh … From … All I remember – I don't remember the specific words …*
>
> *Sgt [redacted] Mmhmm*
>
> *Cst [redacted] …but just that she had an endorsed warrant but she is intoxicated so it would be good to get her before a nurse (overtalking) …*
>
> *Sgt [redacted] Okay. So you had some …*
>
> *Cst [redacted] … something…*
>
> *Sgt [redacted] …sort of comment…*
>
> *Cst [redacted] …along those lines.*
>
> *Sgt [redacted] …to that effect.*

Cst [redacted] Verbally yeah.

27. **0852 am digital CCTV time clock from VPD Jail E Cordova St.** From the CCTV images she is unsteady on her feet as she exits the police vehicle. It shows her being unable to walk without assistance as both officers held her under each arm. She was unable to maintain her balance in a standing position. Her back was placed against a wall for support by both officers. From there she is placed into a wheelchair which had been obtained by Cst [redacted] after which she is wheeled away by the jail guards. The officers then returned to their vehicle.

28. Cst [redacted] did not recall who filled out the Jail Arrest form. Of what was written, it is not his handwriting. As for Cst [redacted] he notes the video does not show this form being handed over to the jail guard commenting that the affected person had been brought into the jail rather than the pre-hold area. The suggestion seems to be that the difference in the point of delivery may have had an effect on the presentation of the Jail Form but there is lack of clarity on this point. Furthermore, as for the contents on the Form itself the officer notes it is not his handwriting although it is his badge number. Sgt [redacted] also observes that the form speaks of "Medical Remarks"` and nothing was noted. The officer was unable to make any comment on this aspect. The written words under the heading "Circumstance Of Arrest" states this:

Accused had difficult night called EHS has warrant

While noting the above lack of recall, he explains that he did not feel there was a need to mark the "suicide" part of the form as there were no concerns.

29. Special Cst [redacted] a jail guard, had been informed about the arrival of the affected person and to give assistance at the sally port. The affected person was placed into a wheelchair. She was then wheeled into the jail reception area by her and a male guard. Csts [redacted] and [redacted] were not involved in this process. They had already returned to their vehicle. The guards then laid her on the ground for the purposes of a search and then returned her to her wheelchair. Throughout she was unable to stand. Special Cst [redacted] asked her if she was on drugs or had taken anything which would cause an overdose. She said no.

30. From the IIO statement Special Cst [redacted] had asked the jail nurse if she would take a look at the affected person. After conferring with her that the affected person was breathing and conscious she responded that she would check in on her during her hourly rounds.

31. **0900 am**. Special Cst [redacted] the Acting Supervisor of VPD jail, relates that she became aware of the affected person at about 0900 hours noting she appeared intoxicated. She gave assistance to [redacted] in placing her in her wheelchair.

32. The affected person was assigned to cell 153 which is used for those with mental health issues or others who require closer attention. It has a mattress on the ground and is closest to the hall staff counter area. It is viewed as the best location for those with safety concerns. She would be checked by staff every 15 minutes with observations recorded on a log. Nothing untoward was noted.

33. In an interview with the Investigator on April 23, 2024 Special Cst [redacted] felt it was a standard booking of an intoxicated person. She had no indication there were any special medical issues beyond intoxication. Nor would anything have been done differently even if the Jail Form had been completed with the fields noting possible suicide or intoxication had been checked off.

34. **About 12 noon**. Nursing Manager [redacted] was working that day with nurse [redacted] She was aware of the arrival of the affected person but neither she nor [redacted] went to her. She noted that if a prisoner arrives on warrants or charges the nursing staff do not go to them. Having stated this she did observe her to be alert enough to sit in her wheelchair and could be heard yelling. She adds that usually nursing staff would go out to a person if they are in custody for a breach or severely intoxicated but this is not a consistent practise commenting that usually, they are searched first, allowed access to counsel and then brought to the nurse. She added that if the staff felt something was wrong they would be taken to the nurse first. The nurses do their checks every hour. [redacted] did the first one at 10am and found her sleeping and lightly snoring. At 11am [redacted] check she was still sleeping and lightly snoring. The noon check by [redacted] resulted in a “Code Blue” declaration. Life saving measures were engaged but she died. She was pronounced dead at 1249 hours.

35. Nurse [redacted] stated that the affected person was not assessed upon her initial arrival in custody. She noted that usually if a person is placed in the drunk tank due to intoxication the nurse will carry out an assessment. However, she advises that they were not informed of her being brought into custody.

36. An autopsy report by the coroner says the cause of death was complications of cirrhosis of the liver plus combined prescription drug and alcohol intoxication. The doctor observed that even if she had more timely medical intervention in an ER hospital setting there is no certainty whether she would have been saved from death given the sudden cardiac arrhythmia and respiratory depression due to her complex long-standing chronic and severe liver disease plus alcohol and prescription drug use.

37. Part of the narrative includes communication recorded on CAD that says this:

"Has a couple of pills."

Cst [redacted] noted that he did not recall reading or hearing this over the radio prior to arriving on scene and entering the building. The Investigator remarks upon comparing the time lines of the radio broadcast to CAD this communication seems not to have been noted by the officers and may have occurred as the officers were in the process of exiting their vehicle upon attendance at the affected person's residence.

VPD POLICY
1.4 ARREST & DETENTION

38. 1.4.6. Arrest of Persons with Injuries or Other Apparent Medical Risks

POLICY

People in police custody are vulnerable, and entirely dependent on the police to obtain medical assistance for them. Members are responsible for the well-being and protection of people in their custody, and must ensure that a person in custody receives appropriate medical assistance.

PROCEDURE

1. If a member believes a person in custody is in need of medical assessment or treatment, the member must request the attendance of BC Ambulance Service (BCAS), Vancouver Fire and Rescue Services (VFRS) or other medical professionals; and

2. Ensure the person in custody is transported to hospital if they

c. are suspected to have ingested anything that may cause a medical emergency and/or overdose; or

d. are incapable of making a rational decision with respect to medical treatment due to intoxication, mental health issue, and/or other medical condition such as a head injury

e. wish to be transported to hospital for one of the following reasons:

3. is suffering from any other obvious medical concern requiring emergency medical treatment.

8. Members should indicate on the Jail Arrest Report if a person in custody required medical attention prior to arrival at jail.

SECTION 77(3)(m)(ii) AND THE LAW

39. Section 77(3)(m)(ii) of the Police Act says this:

(3) Subject to subsection (4), any of the conduct described in the following paragraphs constitutes a disciplinary breach of public trust, when committed by a member:

(m) "neglect of duty" , which is neglecting without good or sufficient cause, to do any of the following:

(ii) promptly and diligently do anything that it is one's duty as a member to do;

40. One must be mindful of a change in the "mental intent" test from amendments to the Legislation made In 2010. PCC Lowe made these

observations concerning the shift in the assessment at page 4 of his decision OPCC 2011-6912:

> *The changes to the Police Act in 2010 removed the mental requirement of "intentionally or recklessly" in the misconduct of Neglect of Duty. This removal of mental requirement resulted in the commensurate change from the requirement of "without lawful excuse" to "without good or sufficient cause". This removal of the requirement for proof of a subjective mental state and the moderation to the standard of "without good or sufficient cause" is consistent with a legislative focus on an objective standard of reasonableness in determining whether or not a neglect of duty constitutes misconduct.*
>
> *In my view the use of the term "good or sufficient cause" broadens the basis upon which a Neglect of Duty may be excused from misconduct beyond its legislative predecessor "lawful excuse."*
>
> *In reviewing the misconduct of Neglect of Duty as set out in s. 77(3)(m)(ii) of the Act, the statutory elements should be applied are as follows:*
>
> *1. The determination of whether a duty exists in the circumstances, and if so, the nature of the duty;*
>
> *2. Whether or not the conduct of the Officer constitutes neglect of that duty; and, if so,*
>
> *3. Whether there exists good or sufficient cause to excuse the neglect.*
>
> - *Good or sufficient cause: objective standard of what a reasonable police officer with similar training, knowledge, skills and experience would have done in the same circumstances.*
>
> - *The spectrum of performance spans from when a member clearly takes no action and fails to perform any aspect of their required duties, through to level in which a member performs their required duties in an exemplary manner. The difficulty in determining whether misconduct has occurred lies in the middle of the*

> *spectrum and must be resolved through the application of the objective standard of reasonableness in terms of an Officer's conduct.*

41. From the FIR reference was made to *Korchiniski v Office of the Independent Police Review Director*, 2022 ONSC 6074 noting that the neglect of duty being examined must be wilful and serious. At paragraph 45, it states mere failure to comply is not sufficient. The court noted there must be some evidence of deliberateness or recklessness or some meaningful level of moral culpability.

42. Reliance on this decision should be taken with care as the terms of reference in the Ontario legislation is different from that of BC. The former imports notions of the absence of lawful excuse or adequate reasons to excuse the failure to discharge the duty whereas section 77(3)(m)(ii) of the BC Act does not. The elements of proof are different. The focus of the Police Act is whether "good or sufficient cause" has been established.

43. Assessing "good or sufficient cause" is one of reasonableness as determined on an objective basis. The legislation does not incorporate words that would import a subjective analysis such as found in other provisions of the Act which requires an assessment of "willfulness or recklessness." Thus, objectively considered, the analysis is focused on what a reasonable police officer with similar training, knowledge, skills and experience would have done in the same circumstances.

44. Furthermore, an analysis which includes the consequences of the breach, whether tragic or otherwise, does not address whether the conduct itself amounts to misconduct. This is an irrelevant ex post facto analysis that is not determinative of whether the conduct under scrutiny is that of a reasonable officer.

45. What the objective standard of a reasonable officer might be is also reflected in the high duty of care officers have as stated in VPD Policy 1.4.6, Arrest and Detention. It deserves repeating to note the words used:

> People in police custody are vulnerable, and entirely dependent on the police to obtain medical assistance for them. Members are responsible for

the well-being and protection of people in their custody, and must ensure that a person in custody receives appropriate medical assistance.

DISCUSSION AND ANALYSIS
ALLEGATION OF MISCONDUCT

46. In this part I am mindful of my earlier discussion at paragraphs 8, 9 and 10 of the limitations of this type of review. This is a preliminary review of the allegation to determine if there appears to be sufficient evidence to substantiate misconduct. Final determinations of facts and law are left to the discipline proceeding.

47. In summary, the questions to be answered as to whether there has been a "neglect of duty" are these:

1. Does a duty exist and if so its nature?

2. Does the conduct under consideration amount to a breach of that duty?

3. Is there "good or sufficient cause" to excuse the neglect as objectively considered from the standard of a reasonable police officer with similar training, knowledge, skills and experience in the same circumstances?

48. While there is a duty of care owed by the officer to the affected person as she had been taken into custody, an evaluation will also be required as to the type of duty keeping in mind her physical condition.

49. From the FIR, the officers had initially attended her residence for a wellness check as there had been a 911 call. Cst [redacted] had determined she was not going to be taken into custody pursuant to the Mental Health Act but as there was an outstanding warrant she was to be arrested, fingerprinted and released.

50. Noted is what appears to be a rapid deterioration of her physical well-being while in the care of the officers. It seems Cst [redacted] was alert to this anomaly in her medical state.

51. On initial contact she acknowledged she had been drinking throughout the night yet there was no evidence of alcohol impairment. Her speech and thought process appeared to be responsive. There was no odour of alcohol. The CCTV images appears to confirm she had good control over her motor skills as she navigated the halls and stairwell of her residence.

52. Upon arrival at the Cambie VPD office about 15 minutes had passed. It would seem there was a distinctive deterioration of her physical well-being. She appears to require assistance in her movement as she walked up the steps of the office and was lethargic. Cst [redacted] had asked her if she had taken any drugs or medication which she responded negatively.

53. Another 15 minutes passed after departing from Cambie Street until their arrival at the Cordova Street jail. It seems her condition had significantly deteriorated. She appears unable to walk on her own accord. She seems to require support against a wall by the officers in order to remain in an upright position until she was seated in a wheel chair. It seems that none of her apparently rapid changes in her physical condition were related to those at the jail. It also seems it was not recorded on the Jail Form. As to whether he had otherwise communicated with the jail staff as to why she was there, the evidence seems to be equivocal. His statement relates, to the best of his recollection, "she had an endorsed warrant but is intoxicated so it would be good to get her before a nurse" or some words to that effect.

54. After the officers departed, it appears her incapacity was such that she was laid down on the jail floor for the purposes of a search. Intoxication was noted as the causation of her condition as evidenced by others at the jail. It would seem there was no other evidence to alert them to other health issues which might prompt them to other protocols addressing health and wellness. About noon code blue was declared and she was pronounced dead at 1249 pm.

55. To be weighed is what a reasonable officer ought to have done in these circumstances. Cst [redacted] had noted his concerns for the affected persons condition. While the officer expressed that he thought it was more efficacious to have her examined by the jail nurses given his experience at the jail rather than a hospital ER setting, whether this decision amounts to "good and sufficient cause" will require findings of fact and rulings of law. Questions remain to be assessed upon

the whole of the circumstances, when objectively considered, and on the balance of probabilities, whether this is what a reasonable officer would have done. The same question also relates to the decision to go to the jail in the face of the Procedure set out in Policy 1.4.2 which speaks about taking the affected person to the hospital if they are unable to make a rational decision with respect to medical treatment given intoxication.

56. Thus an assessment must be made as to whether the officer followed his duty pursuant to policy 1.4.2 to ensure the safety and well-being of a person in his custody and did he do so "promptly and diligently" as set out in the legislation.

57. I conclude for the purposes of this s 117 review there is sufficient evidence which appears to substantiate (1) Allegation of Misconduct contrary to section 77(3)(m)(ii)

> "Neglect of duty" in neglecting, without good or sufficient cause, to promptly and diligently ensure the well-being and protection of the affected person with appropriate medical assistance.

NOTIFICATION OF MISCONDUCT ALLEGATION (1) AND NEXT STEPS SECTIONS 117(7) AND (8)

58. Applying the standard of review at this stage of the proceedings, pursuant to Section 117(9) and 117(8)(d)(i) of the Police Act, I find there appears to be evidence set out in the FIR which, if proven, could substantiate Misconduct Allegation (1)

59. I hereby notify Cst. [redacted] of the next steps in this proceeding pursuant to Section 117(7) and (8) of the Police Act.

60. Cst. [redacted] will be offered a prehearing conference pursuant to Section 120 with respect to Misconduct Allegation #1. If he declines a prehearing conference, a discipline proceeding must be convened within 40 business days of this Notification, or by October 21, 2024.

61. I direct that Cst. [redacted] advise the Registrar whether he accepts a prehearing conference within 5 business days upon either the later of:

1. The expiry of 10 business days of the time for making a request for witnesses under Section 119(1); or
2. The expiry of 5 business days of a decision by the discipline authority pursuant to Section 119(3)(a) accepting or rejecting a request to call witnesses.

62. If Cst. [redacted] does not accept the offer of a prehearing conference within the time frame set out in the paragraph above, the offer is withdrawn and a discipline proceeding will be convened on October 21, 2024.

63. The range of disciplinary and corrective measure set out in Section 126(1) which I would consider appropriate in the current case subject to the constable's service record of discipline includes:

(a) Require the member to take training or retraining relating to the duty of care of prisoners, Section 126(1)(f);
(b) A suspension from service without pay, Section 126(1)(c);
(c) A written reprimand, Section 126(1)(i).

Brent G. Hoy
Section 117(4) Police Act
Appointed Retired Judge
August 21, 2024