**Public Complaint Commission**
300 – 1919 Saskatchewan Drive
Regina, Canada S4P 4H2

**Report from the Public Complaints Commission:**

**"In the Matter of a Public Complaint against the Prince Albert Police Service"**

**Introduction:**

On February 11, 2022, the Public Complaints Commission (PCC) received a request from the Prince Albert Police Service (PAPS) to open an independent investigation into the circumstances surrounding the death of an infant (**Affected Person 1 or AP1**) following the response of PAPS officers to a call for service. As this matter concerned the death of an infant that may have resulted from the actions or inactions of PAPS officers, the PCC was notified in accordance with section 54 of *The Police Act, 1990* (the **Act***)*. The PCC subsequently directed an investigation into the matter pursuant to sections 45 to 48 of the **Act**.

The PCC investigation team was directed to investigate the public complaint and determine whether the conduct of the PAPS officers during the initial call for service constituted a possible incident of misconduct or a possible offence under an Act of the Parliament of Canada.

**The Public Complaints Commission:**

The Public Complaints Commission is an independent civilian oversight agency with a legislative mandate to investigate public complaints arising from the actions of municipal police officers, among others.

The PCC is led by a board of five members appointed by the Lieutenant Governor in the Council. Pursuant to section 16(3) of the **Act,** at least one member must be a person of First Nations ancestry, at least one member must be a person of Métis ancestry, and at least one member must be a lawyer.

The PCC employs a team of experienced investigators and dedicated support staff, led by a Director of Complaints. Pursuant to section 39 of the **Act***,* the PCC has the statutory authority to gather, secure and review all necessary evidence as part of any investigation. Upon the completion of an investigation, the assigned investigator will present their findings and recommendations to the board.

If the PCC board is of the opinion that any part of the complaint, is substantiated and may constitute an offence under any Act, including the *Criminal Code of Canada*, it will refer the file to the Crown for consideration of charges.

If the board is of the opinion that any part of the complaint is substantiated and may constitute an offence under the **Act**, or its Regulations, it will make recommendations to the Chief of the Police Service.

Decisions regarding the conclusion of public complaints are made independently by the PCC, but decisions regarding penalty or discipline are beyond the purview of the PCC and are made by the Chief of the service.

**The Public Complaints Commission Investigation:**

The PCC's investigation of the February 10th, 2022 complaint was comprehensive and challenging. An experienced PCC investigator investigated the complaint to completion. As part of the investigation, the PCC collected evidence from: subject officers, witness officers, in-car video recordings, audio recordings

of the 911 call, PAPS information management system records, dispatch records, cell phone records, CCTV recordings, autopsy reports respecting **AP1,** and internal PAPS policy documents. The evidence provided the requisite context for the PCC to create the following Narrative and make the following conclusions in this public report.

**Timeline and Narrative**

The mother of **AP1 (AP2)** stated that on February 10,2022, **KB,** the father of **API,** left to go to the liquor store at 8:00 pm or 9:00 pm. **KB** returned sometime later, and the two spoke about their relationship. Later in the night, an argument broke out, and **KB** assaulted **AP2**. The argument woke up **AP1,** who began to cry.

At 3:00 am, **AP2** left to go to her relative's residence. Upon arriving, **AP2** learned her relative no longer lived there. **AP2** then walked to an RCMP facility, but there appeared to be no one in attendance at that time. CCTV footage depicts **AP2** arriving at the front doors at 3:27 am and departing at 3:32 am.

At 4:30 am **AP2** returned to the residence and spoke to **KB**. In her later statement to investigators, **AP2** stated that **KB** was intoxicated and had blood on him. **AP2** then went to a neighbour's and asked to borrow their phone.

At 5:44 am, the PAPS received a 911 call from **AP2** requesting police assistance regarding a family dispute. **AP2** informed the 911 operator that **KB** was intoxicated and had assaulted her when she returned to get **AP1** and her clothes.

**AP2** then advised the 911 operator that **AP1** was in the residence with **KB** and, when asked if she was concerned that **KB** might hurt **AP1, AP2** became emotional and said that "*he already does*" and that **KB** *"hits him…he hits him when he puts him to bed".* She said that **AP1** was sleeping at that time.

At 5:47 am, **Subject Officer 1 (SO1)** and **Subject Officer 2 (SO2)** were dispatched to the call. Recordings from the radio dispatch between the 911 operator and **SO1** are consistent with the initial dispatch ticket information; **AP2** had been assaulted and was fearful for the safety of **AP1**.

While en route to **AP2's** location, searches were performed on Canadian Police Information Centre (CPIC) and PAPS local records for additional information on **KB.** The search revealed one PAPS file stemming from a previous Police and Crisis Team (PACT) investigation. EMS had requested the PACT team attend a mental health call for service involving **KB**.

At 5:50 am, **SO1** and **SO2** separately arrived on the scene and spoke with **AP2** outside of the residence.

**AP2** informed **SO1** and **SO2** that **KB** was intoxicated and had pushed her down the steps. **SO2** asked **AP2** if she or anyone else was hurt or needed an ambulance, to which **AP2** replied in the negative, stating that she just wanted to get her clothes and her child, and wait for her ride to come from La Ronge.

**SO1** responded that **AP2** could not stay outside in the cold with a child and wait for a ride coming from La Ronge. **AP2** told **SO2** that the residence was in **KB**'s name. **SO1** and **SO2** then approached the residence and knocked on the front door.

Both officers identified themselves as PAPS officers and **KB** came to the window. **KB** refused to open the door and spoke to the police through the window. **KB** told **SO1** and **SO2** through the window that since **AP2** wanted to leave, she should go. **SO1** later stated that **KB** did not appear intoxicated and **AP2** did not want officers to pursue an assault investigation against **KB**.

As a result, **SO1** and **SO2** determined that they had no grounds to arrest **KB,** or any authority to enter the property by force.

Efforts were then made to find a location for **AP2** to stay for the night. None were available. The woman's shelters were apparently full and **SO1** and **SO2** understood that they would not take in any new clients.

As **AP2** had no place to go and no immediate ride, **SO1** believed **AP1** would be safer in the warmth of the house with his father, than outside in the cold waiting for a ride to come from La Ronge.

**SO1** then advised **AP2** that since there were no available places to take her, the only option would be to spend a few hours at the PAPS detention center, but that it was up to her if she wished to do so. **S01** called **S02**, who had left to go to the police office, and advised him that **AP2** now wished to stay in cells for a few hours, if that was an option given that she was sober. **S02** advised they could do so and list her as intoxicated. He stated he would go to cells and start the paperwork.

At 5:58 am, **AP2** agreed that she would go to cells and got into the backseat of **SO1**'s police vehicle unassisted. This interaction was captured on the police vehicle's recording equipment, and both the question and **AP2**'s response are recorded. Although it has been stated that **AP2** was handcuffed when taken to the PAPS detention center, the in-car camera audio and video from **SO1**'s police vehicle show that **AP2** was not handcuffed. **AP2's** hands were resting on her knees throughout the drive. Likewise, it has been stated that **AP2** was crying and begging **SO1** and **SO2** to help **AP1**; however, the in-car camera audio and video show that **AP2** was calm and there was no conversation between **AP2** and **SO1** on the way to the PAPS detention center.

At 6:02 am, **SO1** arrived with **AP2** at PAPS detention and met **S02** and the cells Sergeant (**WO1**). The video recording of the parties' arrival at the PAPS facility shows **AP2** walked into the facility unrestrained and unassisted, slightly behind **SO1**, in a manner that is not consistent with **AP2** being under arrest or in custody. **WO1** began her shift at 5:45 am and was posted to cells. **WO1** was responsible for the caring and handling of prisoners in the cell block area. **WO1** had been informed that **AP2** was being brought in for intoxication, but when **SO1** arrived with **AP2,** there was a brief discussion among **SO1, SO2** and **WO1** about whether **AP2** was intoxicated. It was clarified to **WO1** that **AP2** was not intoxicated and just needed a place to sleep for a few hours. **WO1** questioned **AP2**, and confirmed she was not intoxicated.

**WO1** asked **AP2** if she wanted to be lodged for a few hours and **AP2** said that she did.

At 6:09 am, **AP2** was searched by officers, medically assessed by the EMT on duty and then taken to a cell by **SO1**. **AP2** was housed in cells from 6:09 am to 9:07 am and then released. On her release, **AP2** was asked whether she had anywhere to go, any family to support her or any plans. **AP2** indicated she had nowhere to go, no family around and that she planned to see her worker.

It has been stated that, while lodged at the detention center, **AP2** tried repeatedly to tell PAPS police officers that **AP1** was in danger, but that they ignored her or advised it was not their job to help her. A review of the detention center and cellblock audio and video does not substantiate this version of events.

A witness who provided a media interview has stated that, while detained in the cellblock area, he could hear a female yelling for the police to help her get her baby. The PCC investigator made multiple attempts to contact the witness in order to interview him. The PCC investigator attended the witness's residence multiple times and was told the witness was not there. On the last attempt, a female answered the door and told the investigator not to come back as the witness would not be there whenever the investigator came. The witness did not make himself available for an interview.

A review of the audio and video recordings from the detention and cellblock areas does not support the witness's claim. Detention and cellblock video footage of **AP2**'s time lodged in cells is unremarkable. **AP2** was provided with toiletries, dry clothing and a drink, and appeared to be resting quietly.

At 10:45 am, police dispatch received a call in which the male caller indicated that he had killed his baby. Upon arrival of PAPS officers, **KB** was arrested after police located **AP1** deceased within the residence.

It should be noted that after the PCC investigator conducted interviews with multiple officers and reviewed internal PAPS policies, the investigator concluded that PAPS does not have a policy for lodging sober consenting persons in cells. The practice of some police services offering night shelter to persons in winter has occurred in the past. The PCC is aware that one police service leaves its secure front lobby area unlocked to allow vulnerable persons access to a warm place to stay, but allows those persons to leave if they choose.

With no policy to guide PAPS officers, the current practice of placing sober persons in cells places PAPS officers in a difficult position when encountering people with nowhere to go and no safe alternatives available. Officers must either bring sober, consenting persons to cells, or leave the person to fend for themselves in the harsh winter.

**Conclusion:**

The circumstances on the morning of February 10, 2022, amount to a tragic and potentially avoidable incident.

**AP1** was, at all relevant times, vulnerable and in danger while inside the residence with **KB**.

**AP2** left the residence at approximately 3:00 am. The status of **AP1** was unknown until 10:40 am when the PAPS received a call from **KB** about a deceased infant.

At 5:44 am, after the PAPS received a 911 call requesting assistance in a domestic dispute involving an infant, **SO1** and **SO2** were outside the residence for 13 minutes and neither officer attempted to check on the well-being of **AP1**.

Both officers indicated in their reports that **AP2** did not mention any concerns about the child's safety at the scene; this is supported by audio recording. However, it is unclear if either officer asked specific

questions relating to the safety of **AP1**, despite being informed of the concerns raised by **AP2** in her 911 call, and identified in the 911 dispatch.

**SO1** and **SO2** should have entered the residence to ensure the safety of **AP1**. **SO1** and **SO2** were incorrect in their belief that they required a warrant or permission from **KB** to enter the residence. Under these circumstances, they did not. **SO1** and **SO2** had the authority to enter the residence under the common law duty to preserve life. Additionally, **SO1** and **SO2** would also have been justified in entering the residence to assist **AP2** in taking **AP1** and collecting her belongings.

**SO1** and **SO2** also failed to follow the PAPS intimate partner violence (IPV) policy. The PAPS IPV policy requires PAPS members attending an IPV call to "ensure the immediate safety of the complainant and any children who may be present". Adherence to the IPV policy required **SO1** and **SO2** to ensure the safety of **AP1** before leaving the scene.

While an interpersonal violence coordinator was not available, street supervisors were available for assistance. A review of call records showed that neither **SO1** nor **SO2** made any calls requesting additional assistance regarding the safety of **AP1**.

Furthermore, **SO1** and **SO2** did not obtain a victim impact statement regarding the alleged assault against **AP2**; nor did they take information concerning **KB's** level of intoxication and whether he was safe to be alone with **AP1**.

The totality of the circumstances demonstrates a series of compounded failures by **SO1** and **SO2** when they had a legal duty to investigate the 911 call by **AP2**. This was neglect of duty by both **SO1** and **SO2,** contrary to section 36(c) of *The Municipal Police Discipline Regulations, 1991,* in failing to conduct a proper investigation of a domestic violence situation despite the presence of a vulnerable and unprotected infant. No neglect of duty is identified regarding other Subject Officers.

As required by S.45 of the **Act** when the actions of a member may constitute an offence, the investigation was forwarded to the Public Prosecutions for review. The Crown did not recommend a criminal charge against the subject officers as, at autopsy, the pathologist was unable to determine **AP**'s time of death during the 3:00 am to 10:40 am window. **KB,** through his counsel, declined to be interviewed by the PCC or to provide evidence on this point.

PCC's investigation has been completed, and we have concluded our file. In accordance with the **Act,** the matter is remitted to the Chief of PAPS for the imposition of any discipline that may be appropriate.