



Royal Canadian
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Alan C. Hubley
Staff Sergeant Major
Administration NCO
RCMP - "M" Division

Your File - Votre référence

PC-2008-3266

Our File - Notre référence

2008-1508182

The Commission for Public Complaint Against the RCMP
Bag Service 1722, Station "B"
Ottawa, Ontario
K1P 0B3

Date

February 16, 2010

Mr. Raymond Silverfox - In Custody Death - Chair Initiated Public Complaint

This letter of disposition refers to your correspondence to the Commanding Officer, "M" Division dated December 12, 2008 outlining your chair initiated public complaint relating to the in-custody death of Mr. Raymond Silverfox at the Whitehorse RCMP Detachment cell block on December 2, 2008.

A. Background Information:

Late in the evening of December 1, 2008 Mr. Silverfox and his girlfriend, Ms. Jill Skookum, traveled from Carmacks, Yukon to Whitehorse, Yukon in a private vehicle with another individual. Mr. Silverfox was celebrating his birthday. Of note, Mr. Silverfox had also been complaining of a cough in the days before his trip to Whitehorse. On the way to Whitehorse a quantity of liquor was consumed. The trio arrived in Whitehorse at about 1:00 AM on December 2nd. Efforts were made to find a hotel room but were unsuccessful. Mr. Silverfox had no money to pay his friend to drive him back to Carmacks.

In an effort to find a place to stay Mr. Silverfox and Ms. Skookum attended to the local Salvation Army shelter. Both were described by staff as appearing to be highly intoxicated. There were no available beds so Mr. Silverfox and Ms. Skookum left the shelter. They returned shortly after and the shelter staff described Mr. Silverfox as appearing like a "zombie". Ms. Skookum revealed that Mr. Silverfox drank a whole bottle of vodka. Mr. Silverfox fell asleep, and about an hour later he began to vomit. The vomiting continued, although it appeared to be only alcohol. Out of concern that Silverfox might have alcohol poisoning the staff called an ambulance.

Emergency Medical Service (EMS) attendants arrived at the Salvation Army shelter at 4:59 AM. Mr. Silverfox was observed to be slumped in a chair. Mr. Silverfox told EMS attendants he had drunk a bottle of vodka. The EMS attendants conducted a physical exam, including taking of vital signs, blood pressure, blood glucose, checking of the lungs and pupils. All of the vital signs were within the normal guidelines. Mr. Silverfox was intoxicated and his speech was slurred, but he was able to stand on his own and walk. Mr. Silverfox did not vomit or "dry-heave" while the EMS attendants were present. Mr. Silverfox stated he did not want to go to the hospital. Mr. Silverfox was not welcome at the shelter and coupled with the fact that it

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was -16 degrees Celsius the RCMP were called to at 5:07 AM to deal with him.

At 5:10 AM, Constables L. Van Marck and D. Bulford arrived at the Salvation Army shelter. They were informed of Mr. Silverfox's state of intoxication. They were also provided with the fact that EMS had concluded Mr. Silverfox did not have to go to the hospital. Constable Bulford arrested Mr. Silverfox, under Section 175 of the Criminal Code for Causing a Disturbance by being drunk. Mr. Silverfox cooperatively walked with the police officers to the police vehicle, where he was searched and placed in the back seat without handcuffs.

At 5:13 AM Mr. Silverfox was booked and lodged in Cell #3 which is commonly referred to as the "drunk tank". This cell is located in the same area as the other cells and is monitored by Closed Circuit Television (CCTV) by the guards. No breath sample was taken with an approved screening device, as is normal practice at the detachment. The reason for this was the fact that EMS attendants had just medically cleared Mr. Silverfox. Mr. Silverfox remained in police custody during the day of December 2nd, 2008.

Corporal C. MacLeod, Watch Commander entered the cell block at approximately 6:34 PM on December 2nd, 2008. In conversation with Mr. Hector MacLellan, the guard who had relieved matron Ms. Balfour, Corporal MacLeod learned that Mr. Silverfox had been sick during the day. This is the first time this information was reported to Corporal MacLeod. Corporal MacLeod became concerned for Mr. Silverfox and she immediately went to the "drunk tank" and observed Mr. Silverfox lying partly on his stomach and side. Mr. Silverfox was not wearing a shirt. Corporal MacLeod could see Mr. Silverfox's bare back and was not able to observe him breathing. Corporal MacLeod noted that Mr. Silverfox's skin tone appeared to be normal. Both Corporal MacLeod and Mr. Hector MacLellan called out to Mr. Silverfox, but received no response. Corporal MacLeod summoned other members to the cell block. They opened the cell door, and Constables M. Muller and K. Hannigan checked Mr. Silverfox for vital signs. They were unable to locate a pulse. Police officers immediately began CPR and continued same until the Emergency Medical Services (EMS) personnel arrived and took over the care of Mr. Silverfox.

Corporal MacLeod instructed the guard to call dispatch for an ambulance at 6:43 PM.

EMS attendants arrived at 6:47 PM and continued attempts to revive Mr. Silverfox. Some heart activity was found and Mr. Silverfox was taken to the Whitehorse General Hospital where he was pronounced dead by Dr. Himmelsbach at 9:15 PM.

B. Nature of CPC Complaint:

On December 12, 2008 the Commanding Officer, "M" Division received a letter from the Chair of the Commission for Public Complaints Against the RCMP outlining three issues to be addressed as a chair initiated public complaint.

1. whether the RCMP members or other persons appointed or employed under the authority of the RCMP Act involved in the events of December 2, 2008, from the moment of initial contact and arrest, through to the subsequent detention and death of Raymond Silverfox, complied with all appropriate training, policies, procedures, guidelines and statutory requirements relating to persons held in RCMP custody and in particular to providing access to medical treatment;

2. whether the RCMP members at the Whitehorse RCMP Detachment provided adequate supervision and direction to the guard or guards who were charged with the care and handling of prisoners in the custody of the Whitehorse RCMP during the period of Mr. Silverfox's detention and subsequent death; and

3. whether the RCMP national, divisional and detachment-level policies, procedures and guidelines relating to the provision of medical treatment to persons detained in RCMP custody, in particular relating to those who are detained where the consumption of alcohol is a factor, are adequate to ensure the proper care and safety thereof.

C. Finding of the Investigation:

An immediate investigation was begun into Mr. Silverfox's death. The investigation was originally commenced by the "M" Division Major Crimes Section. Subsequently, the investigation was taken over by the "E" Division Major Crimes Section of the North District out of Prince George, British Columbia on December 3, 2008. In addition the Commanding Officer "M" Division also ordered an Independent Officer Review be conducted by Inspector Yvon de Champlain, "K" Division, Edmonton Commercial Crime Section.

AUTOPSY:

On December 5, 2008, an autopsy was conducted on the body of Mr. Silverfox by Dr. Charles Lee at the Vancouver General Hospital, Vancouver, BC. Constable J. McDonald, "E" Division Major Crime attended the autopsy.

On February 12, 2009, an Autopsy Report was received from the Office of the Chief Coroner, Department of Justice, British Columbia regarding Mr. Silverfox's death. The Autopsy Report was completed by Dr Charles Lee. MD, FRCPC, Forensic Pathologist.

The Report documented the following:

Principal Pathological Findings:

1. Growth of group B beta hemolytic streptococcus, K. pneumoniae, and E. Coli in cultures.
2. Finn, dark lungs. Minimal inflammation.
3. No coronary artery disease.
4. No significant injuries.
5. Negative toxicology.

Part I: Principal cause of Death

a. Sepsis and Acute Pneumonia

It was the opinion of the pathologist that given the principal cause of death for Mr. Silverfox it was probable that he would have succumbed whether he was in the hospital or in RCMP custody.

The following is documented in the autopsy report prepared by Dr Lee:

"The most significant finding at autopsy were markedly edematous and hemorrhagic lungs. There appear to be some areas of possible consolidation. Postmortem cultures grew several bacterial organisms suggestive of aspiration pneumonia. Microscopic examination of the lungs showed abundant hemorrhage and edema fluid, along with extensive bacterial organisms noted. However, there was minimal inflammation, which suggest either very early pneumonia, or possibly a depressed immune system that is unable to mount a vigorous response. Other autopsy findings included ischemic injuries to the small bowel and brain consistent with his prolonged down time. The liver showed moderate steatosis only. The remainder of the organs were unremarkable. Postmortem toxicologic examination was unremarkable. His admission ethanol concentration was very low. His postmortem blood was tested for the HIV virus and came back non-reactive. However, HIV testing on postmortem blood can be fairly unreliable."

The investigators conducted interviews with all pertinent witnesses and a report was completed. It was the conclusion of the "E" Division investigator that there was no evidence of any criminal conduct. The investigation report was provided to the office of the Public Prosecution Service Canada, (PPSC) Whitehorse, Yukon. This report was reviewed by PPSC Crown Counsel, Iqaluit, Nunavut. The review determined that there was no criminal culpability on the part of any employee of the RCMP.

The Chair Initiated Public Complaint investigation was conducted by a senior member of the Royal Canadian Mounted Police from "E" Division, British Columbia. The Public Complaint investigation relied on the information which had been gathered during the course of the in custody death investigation completed by "E" Division Major Crime Section North District. The Public Complaint investigator worked in conjunction with the Independent Officer Review member in the course of his investigation. The investigator also conducted interviews with police officers and guards to clarify information provided during the course of the in-custody death investigation. The investigator completed a report which was received at "M" Division Headquarters on December 11, 2009. The report has been reviewed and I am now in a position to respond to your complaint.

For clarity purposes I will address each issue separately:

Term #1 - "Whether the RCMP members or other persons appointed or employed under the authority of the RCMP Act involved in the events of December 2, 2008, from the moment of initial contact and arrest, through to the subsequent detention and death of Raymond Silverfox, complied with all appropriate training, policies, procedures, guidelines and statutory requirements relating to persons held in RCMP custody and in particular to providing access to medical treatment;"

Booking in Process:

Whitehorse Detachment Unit Supplements OM 19.2 states -

- 1.1 "As part of the booking in process, all prisoners suspected of being under the influence of alcohol shall be asked to provide a breath sample in the (digital) approved screening device".
- 1.2 "A prisoner with a BAC of 350% or greater shall be taken to Whitehorse General Hospital for examination/treatment before being lodged in cells".

Finding:

No breath sample was obtained from Mr. Silverfox by the arresting police officers. This was basically due to the fact that Mr. Silverfox had been cleared for incarceration by EMS personnel.

Recommendation:

Constable D. Bulford and Constable L. Van Marck be provided with Operational Guidance with respect to the noted policy and to ensure compliance with this policy is maintained.

National Operational Manual 19.3.4.4.1 states -

"Document the date, time and name of the medically trained professional who certified the prisoner fit for incarceration on form C-13-1".

Finding:

From a review of the C-13-1 completed with respect to Mr. Silverfox it was noted there was no documentation made in regards to the Emergency Medical Service personnel who certified that Mr. Raymond Silverfox was fit for incarceration.

Recommendation:

Constable D. Bulford and Constable L. Van Marck be provided with Operational Guidance with respect to the proper completion of form C-13-1 with respect to this policy.

Guard Training Policy:

It should be noted that the guards at Whitehorse Detachment are employees of the Canadian Corps of Commissionaires. Guards at Whitehorse Detachment receive training in accordance with RCMP Training Course CS CL 8500. Mr. Harry Elliot is responsible for guard training at Whitehorse Detachment. He is employed by the Canadian Corps of Commissionaires and holds the title: Employee Relations Advisor - Company Security Officer - RCMP Guard Program Coordinator, responsible for Victoria, the Islands and the Yukon.

Operational Manual 19.3 Guarding Prisoners/Prisoner Effects.

1.5 "As a condition of employment with the RCMP, all guards must have a valid basic first aid and CPR certificate as well as successful completion of Assessing Prisoner Responsiveness session taught to guards during their initial orientation and subsequent annual re-certification".

National RCMP Operational Manual policy states at 19.3.5.1 - Monitoring Prisoners -

"Check prisoners frequently and at irregular intervals to ensure their security and well being. Ensure the intervals are no more than 15 minutes apart."

RCMP Guard training at Whitehorse Detachment includes the following:

1. RCMP CTS CL 8500 - This is the course training standard for new RCMP Guards.
2. RCMP National Policy on RCMP Guard training. (Includes Ops Man 19.2 Assessing Responsiveness/Medical Assistance.)
3. RCMP Guard Job Description.

Hector MacLellan completed the following training successfully:

- a) Guard training course - 2007-06-12
- b) Standard First Aid and CPR 2008-02-17 Expiry date 2011-02-11
- c) 6 month Guard Refresher course - 2008-01-15
- d) 6 month Guard Refresher course - 2008-12-08

Heather Balfour completed the following training successfully:

- a) Guard training course - 2007-06-17
- b) Standard First Aid and CPR - 2008-04-20 Expiry Date 2011-04-20
- c) 6 month Guard Refresher course - 2008-01-14
- d) 6 month Guard Refresher course - 2008-08-30
- e) 6 month Guard Refresher course - 2008-12-19

Craig MacLellan completed the following training successfully:

- a) Guard training course 2008-06-24
- b) Standard First Aid and CPR: 2008-09-28 Expiry Date: 2011-09-28.

National Operational Manual 19.3.9.1.5 requires a Commander to -

"Appoint one member to be responsible for the orientation, initial training and re-certification of guards. Ensure guard training is equivalent to the RCMP course training standard (CTS) CL8500.

Inspector M. Wharton, Officer in Charge (OIC) Whitehorse Detachment confirmed that he had appointed Constable J. Kalles to be responsible for the orientation, initial training and re-certification of guards. This appointment was on an interim basis. Guards Hector MacLellan and Heather Balfour did not attend annual guard re-certification which was held on June 24, 2008 at Whitehorse Detachment.

A recommendation was made to Constable J. Kalles by Mr. Harry Elliott that -

"The Detachment RCMP guards not in attendance at the training should not be employed as an RCMP guard until they complete the semi-annual refresher training".

National Operational Manual 19.3.9.1.6 requires a Commander to -

"Ensure a guard is given his/her orientation tour of the work site when first hired followed by one tour every six months. Review his/her duties, directives, legal responsibilities, the requirement to be vigilant for medical conditions, abnormal prisoner behavior and rousability."

Finding:

All three guards received their initial orientation and tour of the work site when first hired. However Guard H. MacLellan received a six month refresher on 2008-01-15 and 2008-12-08. Guard H. Balfour received six month refresher training 2008-01-14, 2008-08-30 and 2008-12-19. There was an issue with the timeliness of the 6 month refresher training.

Recommendation:

Inspector M. Wharton, OIC Whitehorse Detachment put a system in place to monitor guard training to ensure that it is completed in a timely manner and in accordance with policy.

RCMP member training:

All RCMP members involved in this incident had valid First Aid and CPR Certification.

National Operational Manual 19.3.9.1.2 requires a Commander to -

"Ensure all members and personnel under your command who are responsible for prisoner care have read and initialed the applicable national directives, divisional and detachment/unit supplements. Repeat this process every six months.

Finding:

Inspector M. Wharton, OIC Whitehorse Detachment confirmed that on the date of this in-custody death there was no process in place to carry out and monitor this directive.

Recommendation:

Inspector M. Wharton, OIC Whitehorse Detachment implement a process to comply with this policy.

National Operational Policy 19.3.5.1 - Monitoring Prisoners requires -

"Check prisoners frequently and at irregular intervals to ensure their security and well being. Ensure the intervals are no more than 15 minutes apart".

Finding:

Physical checks were not conducted in intervals of no more than 15 minutes apart. Guards C. MacLellan, H. Balfour and H. MacLellan prisoner checks were mainly performed by video monitor.

Recommendation:

Inspector M. Wharton, OIC Whitehorse Detachment ensure that operational guidance is provided to all guards working at Whitehorse Detachment to ensure compliance with this policy regarding physical checks of prisoners.

National Operational Policy 19.3.5.4.1 states -

" To constantly monitor means to watch or observe without interruption. Use of CCTV may augment but not replace physical checks. The use of CCTV in RCMP cell blocks must be recommended by the Cr. Ops. Officer and approved by the CO.

Whitehorse Detachment Unit Supplement - 19.3.3.1 - Monitoring Prisoners states -

"The video monitor is in place to allow for an increased level of monitoring and does not constitute a check of the prisoner".

Finding:

Most checks of Mr. Silverfox were done by means of CCTV. The CCTV in Whitehorse Detachment was installed years ago and was recommended by the OIC Criminal Operations of the day and approved by the Commanding Officer at that time.

Recommendation:

Inspector M. Wharton, OIC Whitehorse Detachment provide Operational Guidance to all guards to ensure that CCTV is only used to augment physical checks.

"M" Division Operational Policy 19.1.1.4 states:

"In Detachments with monitoring equipment the guard/matron shall indicate in the guardroom log book if the check was done physically or by way of a monitor. This will be done by writing either "M" (monitoring) or "P" (Physical) in the log beside each entry".

Finding:

The Guardroom Log Book revealed there were no notations made whether the check was a physical "P" check or whether the prisoner check was completed through the use of monitoring "M" equipment.

Recommendation:

Inspector M. Wharton, OIC Whitehorse Detachment ensure that Operational Guidance be provided to all guards at Whitehorse Detachment to comply with this policy requirement.

National Operational Policy 19.3.1.11 requires a senior member to -

"At the commencement and conclusion of a member's or guard's shift, the senior member on duty, accompanied by the guard, will assess each prisoner in every cell and record same".

Finding:

Corporal C. MacLeod, Watch Commander, attended the cell block at the commencement of her shift and reviewed the C-13-1 Prisoner Reports for each prisoner. There was nothing in the Prisoner Log Book of any prisoner assessment or recording of same. There are no notations in the Prisoner Log Book identifying that the previous Watch Commander complied with this policy.

Recommendation:

Inspector M. Wharton, OIC Whitehorse Detachment is to provide Operational Guidance to Corporal C. MacLeod and all members of Whitehorse Detachment to ensure that they comply with this policy requirement.

Whitehorse Detachment Unit Supplement 19.3.12.1 and 12.2 requires members to -

12.1 - "The Watch Commander or in his/her absence, the Senior Constable on shift, has overall responsibility for the Detachment cell block".

12.2 - "At the commencement of the shift, and periodically during the shift, the Watch Commander will physically check the cell facilities and prisoners and record any adverse findings in the prisoner diary book in red ink, inclusive of regimental number"

Finding:

Interviews with Watch Commanders and in particular Corporal C. MacLeod revealed that they were not aware of their responsibility in this area of both National and Whitehorse Detachment policy. Corporal C. MacLeod did attend the cell block at the commencement of her shift but did not return again until approximately 4:00 PM due to other duties. Corporal C. MacLeod stated that she was not aware of her responsibility to record any adverse prisoner conditions in the Guardroom Log Book as per policy. Subsequently there was nothing recorded about prisoner condition. Corporal C. MacLeod confirmed that she was not advised during her shift of the condition of Mr. Silverfox and the number of times he had vomited.

Recommendation:

Inspector M. Wharton, OIC Whitehorse Detachment provide Operational Guidance to Corporal C. MacLeod and all Watch Commanders as to their responsibility with respect to this policy.

National Operational Policy 19.2.2.1 requires a member to -

"If there is any indication that a person is ill, suspected of having alcohol poisoning, a drug overdose, or ingested a combination of alcohol and drugs, concealed drugs internally, or sustained an injury, seek immediate medical assistance".

Finding:

The investigation of this matter revealed that Mr. Silverfox was not well. CCTV surveillance showed that Mr. Silverfox had vomited in excess of 15 times and urinated in his pants over the course of the 13 hours he was in custody. The provisions of this policy were not complied with by the guards or the members who came into contact with Mr. Silverfox throughout his incarceration.

Recommendation:

Inspector M. Wharton, OIC Whitehorse Detachment provide Operational Guidance to all guards/matrons and RCMP members who came into contact with Mr. Silverfox during the course of his incarceration. The provisions of this policy is to be clearly spelled out to each to ensure that they are aware of their responsibilities in this area.

National Operational Policy 19.1.2.1.1 states -

"The member on duty is responsible for ensuring cells are safe and habitable".

Finding:

Mr. Silverfox had vomited in excess of 15 times during the course of his incarceration. From a review of the CCTV the provisions of this policy were not complied with as the cell block cleanliness was an issue.

Recommendation:

Inspector M. Wharton, OIC Whitehorse Detachment is to provide Operational Guidance to all guards/matrons and all members with respect to their responsibility in relation to this policy.

Independent Officer Review:

The Independent Review Officer, Inspector Y. de Champlain made a number of recommendations in his report to the Commanding Officer dated May 26, 2009. The recommendations and the response to these recommendations by the OIC Whitehorse Detachment provided the Commanding Officer "M" Division dated June 16, 2009 are as follows.

Recommendation 1 - That Guards Hector MacLELLAN, Craig MacLELLAN, and Heather BALFOUR's suitability for employment as a guard be reviewed by the OIC Whitehorse Detachment and that they be provided written direction on all requirements set out in the Operational Manual, "M" Division Green Sheets and the Whitehorse Detachment Unit Supplements in regards to Cell Block Security and the Guarding of Prisoners and in particular the following:

a) National OM 19.3.5.1 Monitoring Prisoners Requires: "Check prisoners frequently and at irregular intervals to ensure their security and well being. Ensure the intervals are no more than 15 minutes apart".

b) National OM 19.3.5.4.1 Directs: "To constantly monitor means to watch or observe without interruption. Use of CCVE may augment but not replace physical checks. The use of CCVE in RCMP cell blocks must be recommended by the Cr. Ops. Officer and approved by the CO

c) Whitehorse Unit Supplements - Operational Manual 19.3 - Monitoring Prisoners 3.1 - The video monitor is in place to allow for an increased level of monitoring and does not constitute a check of the prisoner.

d) "M" Division Operational Manual: Ops Man 19.1 Cell Block Security 1. - In detachments with monitoring equipment the guard/matron shall indicate in the guardroom log book if the check was done physically or by way of a monitor. This will be done by writing either "M" (monitoring) or "P" (physical) in the log beside each entry.

e) OM 19.2. Requires of a member to Assess responsiveness and seek medical assistance. Specifically OM 19.2.2.1 requires of a member, "If there is any indication that a person is ill, suspected of having alcohol poisoning, a drug overdose, or ingested a combination of alcohol and drugs, concealed drugs internally, or sustained an injury, seek immediate medical assistance."

Recommendation 1 - Response:

- I have reviewed the service/training files for Hector MacLELLAN, Craig MacLELLAN, and Heather BALFOUR. All three were found to have met suitability for employment standards. Hector MacLELLAN and Heather BALFOUR were both spoken with on July 16th and 20th, respectively. The above noted points "a" to "e" were reviewed and explained.
- Craig MacLELLAN was not spoken with as he had left Canada at the beginning of 2009 to teach in another country and will not be back until spring of 2010.

Recommendation 2 - That the OIC Whitehorse Detachment ensure guards are provided semi-annual re-orientation of the cellblock and their duties as required in OM 19.3.1.5

Recommendation 2 - Response:

This recommendation has been implemented. Currently only one guard is not qualified and he has already been identified with the training expected to take place upon his return to Whitehorse.

He will not be used as a guard until this qualification has been met.

Recommendation 3 - The the OIC Whitehorse Detachment ensure all members and personnel under his command who are responsible for prisoner care have read and initialed the applicable national directives, divisional, detachment and unit supplements. That this process be repeated every six months and initialed records retained as per OM 19.3.9.1.2.

Recommendation 3 - Response:

This recommendation has been implemented with the read and initial document tracked by the Operational Support Sergeant. Same document, once completed, is placed on the appropriate administration file.

Recommendation 4 - That the OIC Whitehorse Detachment ensure a guard is given his/her orientation tour of the work site when first hired followed by one tour every six months. Review his/her duties, directives, legal responsibilities, the requirement to be vigilant for medical conditions, abnormal prisoner behavior and rousability as per OM 19.3.9.1.6 .

Recommendation 4 - Response:

This recommendation has been and will continue to be implemented.

Recommendation 5 - That the OIC Whitehorse Detachment ensure that Watch Commanders understand their responsibilities to the Detachment Cell Block as per Whitehorse Detachment Unit Supplements OM 19.3.12.1

Recommendation 5 - Response:

This recommendation has been implemented and Unit Supplements have been updated to reflect same.

Recommendation 6 - That the OIC Whitehorse Detachment ensure that Watch Commanders will: at the commencement of the shift, and periodically during the shift, will physically check the cell facilities and prisoners and record any adverse findings in the prisoner diary book in red ink, inclusive of regimental number as per Whitehorse Detachment Unit Supplements OM 19.3.12.2.

Recommendation 6 - Response:

This recommendation has been implemented and Unit Supplements have been updated to reflect same.

Recommendation 7 - That the OIC Whitehorse Detachment ensure that the senior member on shift will: "At the commencement and conclusion of a member's or guard's shift, the senior member on duty, accompanied by the guard, will assess each prisoner in every cell and record same as per OM 19.3.1.11.

Recommendation 7 - Response:

This recommendation has been implemented and Unit Supplements have been updated to reflect same.

Recommendation 8 - That the OIC Whitehorse Detachment ensure that a member will assess responsiveness and seek medical assistance for a person in police custody, if there is any indication that a person is ill, suspected of having alcohol poisoning, a drug overdose, or ingested a combination of alcohol and drugs, concealed drugs internally, or sustained an injury, as per OM 19.2.2.1.

Recommendation 8 - Response:

This recommendation has been implemented and Unit Supplements have been updated to reflect same.

Recommendation 9 - That the OIC Whitehorse Detachment develop and enact a policy within the Whitehorse Detachment Unit Supplements in support of OM 19.2.2.1 which directs all members and guards to seek medical attention for intoxicated persons who vomit while in custody in a prone position or vomit excessively considering the possibility of aspiration and the possible development of aspirated pneumonia.

Recommendation 9 - Response:

This recommendation has been implemented and Unit Supplements have been updated to reflect same.

Recommendation 10 - That the OIC Whitehorse Detachment ensure that the member on duty is responsible for ensuring cells are safe and habitable substances (sic) as per OM 19.1.2.1.1. Habitable must be interpreted as being free of vomit, urine or any other bodily substances.

Recommendation 10 - Response:

This recommendation has been implemented and Unit Supplements have been modified with an additional "habitable" clause, to address same.

Recommendation 11 - That the OIC Whitehorse Detachment ensure compliance to Whitehorse Unit Supplements OM 19.2.1.1 and 19.2.1.2 in that: as part of the prisoner booking in process:

1.1 all prisoners suspected of being under the influence of alcohol shall be asked to provide a breath sample in the (digital) approved screening device.

1.2 A prisoner with a BAC of 350 mg % or greater shall be taken to Whitehorse General Hospital for examination/treatment before being lodged in cells.

Further that the policy be reviewed and a clause added to it which requires a member to consider all circumstances and signs of impairment of alcohol or drugs and to consider medical attention if a prisoner's BAC should not exceed 350 mg% after breath sample obtained in the (digital) approved screening device considering all circumstances.

Recommendation 11 - Response:

This recommendation has been implemented and Unit Supplements have been created to address same.

Recommendation 12 - That the OIC Whitehorse Detachment ensures that members " Document the date, time and name of the medically trained professional who certified the prisoner fit for incarceration on form C-13-1, in accordance with OM 19.3.4.4.1.

Recommendation 12 - Response:

This recommendation has been implemented.

Recommendation 13 - That the OIC Whitehorse Detachment consider the establishment of a Community Consultative Group which will include the medical community. The CCG will review the issue of Public Intoxication and provide possible alternatives to incarceration and speak to the medical care of intoxicated persons in the Whitehorse community.

Recommendation 13 - Response:

The CCG was already established and did include representation from the medical community. It is not a robust CCG but efforts continue to try and strengthen it.

Recommendation 14 - That the OIC Whitehorse Detachment:

- a) review National, Divisional and Whitehorse Unit Supplements in regards to Guard training.
- b) ensure that Divisional and Whitehorse Unit Supplements clearly reflect National Operational Manual policy
- c)and that the Guard training requirements at Whitehorse Detachment are clearly reflected and adhered to.

Recommendation 14 - Response:

This recommendation has been implemented. All three levels of policy have been vetted and streamlined to reduce ambiguity and conflicting guidance.

Term #2 - "Whether the RCMP members at the Whitehorse RCMP Detachment provided adequate supervision and direction to the guard or guards who were charged with the care and handling of prisoners in the custody of the Whitehorse RCMP during the period of Mr. Silverfox's detention and subsequent death."

Whitehorse Detachment guards were provided training with respect to their duties by the Canadian Corps of Commissionaires supported by the RCMP. Whitehorse Detachment had and has policy and post orders in place with respect to Cell Block operation and guard duties. Supervision and direction was and continues to be in place with respect to the Cell Block Operation.

A review of the Guard log for the period that Mr. Silverfox was in custody did not have any entries by the members on shift giving any specific instructions about monitoring his condition. Further to this the Watch Commander, Corporal C. MacLeod attended to the guard room at the commencement of her shift at 8:03 AM but did not return until later in the day due to other

duties.

Corporal MacLeod was not aware that it was her responsibility to record any adverse findings in the prisoner diary book in red ink, inclusive of her regimental number. Corporal C. MacLeod was not advised during her shift of the condition of Raymond SILVERFOX and the number of times in which he had vomited. The symptoms displayed by Mr. Silverfox were considered at the time to be a result of his intoxication by alcohol. Unfortunately, we now know that there was an underlying medical condition which was not available at the time. There was a misinterpretation of Mr. Silverfox's condition which contributed to the fact that this information was not passed on to police officers and Detachment management during the course of his incarceration.

The guards did not strictly follow the policy with respect to proper checks of Mr. Silverfox. Entries into the guard log consistent with policy were made however no distinction regarding physical checks or monitoring by CCTV. This error does not mean that the checks were not done, it means that the distinction was not recorded.

Finding:

The RCMP provided training and cell block operation orders to the guards at Whitehorse Detachment. RCMP members who were in the cell block through the time of Mr. Silverfox's incarceration should have ensured that the guards were provided proper direction and guidance in the performance of their duties.

Recommendation:

Insp. M. Wharton, OIC Whitehorse Detachment provide Operational Guidance to all members working at Whitehorse Detachment respecting the need to properly supervise and direct the civilian guards when visiting the cell block.

Term #3 - "Whether the RCMP national, divisional and detachment-level policies, procedures and guidelines relating to the provision of medical treatment to persons detained in RCMP custody, in particular relating to those who are detained where the consumption of alcohol is a factor, are adequate to ensure the proper care and safety thereof."

RCMP policy at all three levels is comprehensive when speaking to the medical needs of prisoners who have been detained where the consumption of alcohol is a factor. It is felt that in general the policy is adequate. Whitehorse Detachment policy is clear that if a prisoner is suspected of being sick that arrangements for medical attention should be made "forthwith". It was a misinterpretation of Mr. Silverfox's condition that resulted in medical attention not being made available "forthwith".

The policy did allow proper care of Mr. Silverfox. Once he was examined by EMS staff and found fit to be lodged in cells both National and Divisional policy speak to either constantly or continuously monitor a prisoner that was medically fit for incarceration. National policy defines constantly as "...to watch or observe without interruption...". This would imply that entries about that prisoner would be less than the fifteen minute intervals that policy allows for in general terms.

Mr. Silverfox vomited in excess of 15 times over a 13 hour period for which he was in custody. This behavior is indicative of a prisoner that may require medical assistance. However misinterpretation of these symptoms as being the result of alcohol intoxication and not some type of medical emergency resulted in his not being provided with medical attention "forthwith".

Consideration can be given to the comments below with respect to changes in policy that may give policy/direction that allow for better care of prisoners.

The national policy that allows a "medically trained professional" to certify a person is fit for incarceration includes an ambulance attendant. In this case Mr. Silverfox had been examined by EMS prior to being transported to cells and seen fit for incarceration. Normally the members would have given him a breath test consistent with Whitehorse Detachment Supplements. However, the fact that he was seen as fit for incarceration by EMS personnel minutes prior to arriving at the cells lead the police officers to conclude that Mr. Silverfox did not require a breath test. The results of a breath test cannot be known. However, it is possible that if it was over 350 mg % Mr. Silverfox may have been transported to hospital for a further medical examination.

The Whitehorse Detachment Supplements list what the duties are of the Watch Commander regarding cell facilities at the commencement of shift. It does not speak to noting any medical needs of the prisoners.

Finding:

National, Divisional and Whitehorse Detachment policy is adequate.

Recommendation:

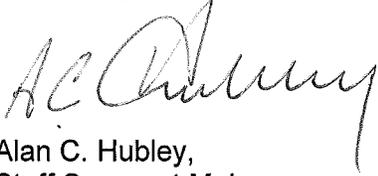
Insp. M. Wharton, OIC Whitehorse Detachment provide Operational Guidance to all RCMP members and civilian guards with respect to the National, Divisional and Whitehorse Detachment policy and the responsibilities of everyone with respect to this policy. Whitehorse Detachment policy should be amended to include a notation by the Watch Commander on any obvious medical needs or the apparent medical condition of prisoners.

Presently, Whitehorse Detachment has a Unit Level Quality Assurance (ULQA) process in place to review the cell block operation. This ULQA is completed on a quarterly basis and involves all aspects of cell block operation. In addition, National, Division and Whitehorse Detachment policy is reviewed on a semi-annual basis. This policy is then circulated to all members and guards for review. There is a process in place to ensure that the policy is actually reviewed by the employees. This process is then documented on the appropriate Whitehorse Detachment administration file.

The Officer in Charge, Criminal Operations, "M" Division has reviewed the circumstances surrounding the death of Mr. Silverfox. As a result he has ordered that a special review of the Whitehorse Detachment cell block operation be undertaken by RCMP Pacific Region Review Services. This review is expected to take place in March or April 2010.

Finally, a meeting is being arranged with a representative of the Silverfox family, the Officer in Charge of Criminal Operations and the RCMP First Nations Policing Coordinator. The purpose of this meeting is to inform the family that this Public Complaint investigation has been completed.

Yours truly,



Alan C. Hubley,
Staff Sergeant Major
Administration NCO
RCMP - "M" Division

4100 - 4th Avenue
Whitehorse, Yukon
Y1A 1H5

cc: Professional Standards & External Review Directorate