**SUPREME COURT OF NOVA SCOTIA**
**Citation:** *R. v. Gardner*, 2022 NSSC 154

**Date:** 20220602
**Docket:** CRH No. 504680
**Registry:** Halifax

**Between:**

Her Majesty the Queen

v.

Special Constable Dan Fraser and
Special Constable Cheryl Gardner

**D E C I S I O N**

| | |
|---|---|
| **Judge:** | The Honourable Justice James L. Chipman |
| **Heard:** | March 14, 15, 16, 17, 21, 22, 23 and 25, 2022 in Halifax, Nova Scotia |
| **Decision:** | June 2, 2022 |
| **Counsel:** | Christian Vanderhooft, on behalf of the Crown<br>Joel E. Pink, Q.C. and Ronald E. Pizzo, on behalf of Cheryl Gardner<br>Mark Bailey, on behalf of Dan Fraser |

**By the Court:**

## INTRODUCTION

[1] On June 14, 2016, 41 year old Corey James Rogers welcomed the birth of his baby daughter. On the next day while in custody he was tragically pronounced dead. Mr. Rogers struggled with alcohol addiction and as our Court of Appeal stated about a year ago, "Corey Rogers should not have died in police custody". The accused persons in this case are the booking officers who were on duty when Mr. Rogers was admitted and subsequently died alone in a cell at the Halifax police station.

[2] By single count Indictment filed March 9, 2021 the co-accused are charged with criminal negligence causing the death of Mr. Rogers on or about June 15, 2016. Both special constable Dan Fraser and special constable Cheryl Gardner entered not guilty pleas on April 13, 2021. Their trial proceeded about 11 months later before Judge, alone. This was a re-trial on account of the Court of Appeal's decision at the conclusion of the conviction appeals on January 28, 2021. Justice Beveridge's written reasons with Justices Farrar and Derrick concurring followed on June 24, 2021; *R. v. Gardner*, 2021 NSCA 52. The Court of Appeal's decision provides a helpful roadmap for analyzing the case before the Court and I have heavily drawn upon their guidance on the law in coming to my decision.

[3] The Crown called eight witnesses and introduced 13 exhibits. Ms. Gardner called three witnesses and introduced one exhibit. Mr. Fraser did not call any witnesses or introduce exhibits, adopting the testimony and exhibit introduced by Ms. Gardner. I have purposely reversed the order of the accused owing to their agreement (maintained throughout the trial) to have Ms. Gardner cross-examine and call her evidence ahead of Mr. Fraser.

## GUIDING PRINCIPLES

[4] Ms. Gardner and Mr. Fraser are presumed innocent of the charge before the Court. This presumption is only displaced if the Crown proves guilt beyond a reasonable doubt. Suspicion of guilt or a belief in probable guilt do not displace the presumption. Only proof beyond a reasonable doubt can establish guilt. The Crown's onus of proving guilt beyond a reasonable doubt never shifts.

[5] A reasonable doubt is based on reason and common sense which must be logically connected to the evidence or lack of evidence. Suspicion and probability

fall far short of the reasonable doubt standard. Proof beyond a reasonable doubt falls much closer to absolute certainty than it does to a balance of probabilities.

[6] Neither accused have to prove anything to be found not guilty. The burden always rests on the Crown to prove beyond a reasonable doubt that they committed the essential elements of the offence charged.

[7] This case involves circumstantial evidence which has the same evidentiary value as direct evidence. Reliance on circumstantial evidence does not change the burden of proof. The Supreme Court of Canada has established that an inference of guilt drawn from circumstantial evidence should be the only reasonable inference that such evidence permits.

## FACTUAL FINDINGS FROM THE EVIDENCE AT TRIAL

### The Lead-up to Mr. Rogers' Arrest

[8] Mr. Rogers' girlfriend, Emilie Spindler, gave birth to their first child, a daughter, on June 14, 2016. Mr. Rogers was at the IWK Grace Maternity Hospital (IWK) for the birth. He left around 3 p.m. the next day to do errands. Ms. Spindler did not see Mr. Rogers again until she was called down to the IWK main reception at around 10:30 p.m. on June 15th.

[9] Mr. Rogers' friend, Ronald Johnston met up with Mr. Rogers during the afternoon of June 15th. They spent about an hour and a half together and Mr. Johnston said (during testimony during the jury trial – transcript filed as part of exhibit 10) that his friend was excited about becoming a father. Asked about Mr. Rogers' level of alcohol consumption, he replied that he exhibited "a slight smell of alcohol …I'd seen him quite intoxicated before, and he wasn't". Mr. Johnston last saw his friend when he dropped him off between 4 p.m. and 5 p.m. at Victoria Park near Clyde Street in Halifax.

[10] There is no more evidence about Mr. Rogers' whereabouts until close to 9 p.m. on June 15th. An "Incident Details" report and video surveillance captured from outside the front entry of the Clyde Street Nova Scotia Liquor Commission (NSLC) store (within exhibit 10) discloses that he attended the store at 20:43. Mr. Rogers was refused admission by the security officer for being under the influence of alcohol. The report states that the "suspect" (photograph and description at p. 3 along with the video identifying Mr. Rogers) had a physical altercation with a panhandler outside of the store. The report also states (on account of video

surveillance) that Mr. Rogers gave cash to another male and that this person purchased a 375 ml bottle of Fireball Cinnamon Whiskey liqueur and thereafter gave it to Mr. Rogers.

[11] Mr. Rogers is next seen on a 12-minute videotape (part of exhibit 10) at and around the IWK front desk. This video is taken from one angle looking out and slightly downwards from the dispatch desk. There is no audio. From the videotape evidence along with the filed transcripts of the evidence of the three IWK personnel (Derek Jefferson, James Diab and Michelle Regan) from the jury trial, I find that Mr. Rogers was intoxicated and generally making a scene. Variously described as belligerent and agitated, staff denied Mr. Rogers' request to go up to visit his girlfriend and baby, instead calling for Ms. Spindler to come down.

[12] Ms. Spindler met with Mr. Rogers and the two can be seen on the video having a conversation in proximity to the front desk. In her testimony filed from the first trial, Ms. Spindler allows that Mr. Rogers had been drinking and that he was intoxicated but that, "I've seen him worse". The two can be observed exiting the IWK. By this time Mr. Rogers had been repeatedly asked to leave and Ms. Regan called the police.

[13] The next 12-minute video clip is taken from the outside "woman's loop" entrance to the IWK off of University Avenue. Mr. Rogers is seen being guided out of the IWK by a security guard. The three responding Halifax Regional Police (HRP) officers are soon present on the scene. No doubt in part due to the fact that it is outside and nighttime, the outside video segment is grainy. In any event, I found this evidence to be largely consistent with what Mr. Jefferson, Mr. Diab, Ms. Spindler and the officers stated happened with Mr. Rogers during his interactions with police outside of the IWK.

## **The Responding Officers' Interactions with Mr. Rogers**

[14] Cst. Ryan Morris responded to the initial call concerning Mr. Rogers and was first on the scene. Upon arriving he observed Mr. Rogers and his girlfriend in conversation. As soon as he got out of his police car he saw Mr. Rogers chug half a pint of Fireball Cinnamon Whisky. The bottle was subsequently retrieved from the bushes outside the IWK and traced to the Clyde Street NSLC, thus bringing to light the "Incident Details" report and video from earlier in the day.

[15] Cst. Morris discerned indicia of alcohol consumption in Mr. Rogers; noting slurred speech, thick tongue, swaying, blood shot eyes and odour. On cross-

examination both Csts. Morris and Justin Murphy (who arrived on the scene with his partner, Cst. Donna Lee Paris, shortly after Cst. Morris) agreed that on an intoxication scale of mild, medium and high that Mr. Rogers was between mild and medium. As with the other responding officers, Cst. Morris did not have training regarding the effect of alcohol ingestion on central nervous system failure.

[16] Cst. Paris testified that she had training in dealing with individuals with high blood alcohol content. That said, she did not have specific recall about how much alcohol ingestion could bring about central nervous system failure or the like.

[17] Based on the consistent evidence of Csts. Morris, Paris and Murphy, it is clear that they encountered an intoxicated Corey Rogers on the sidewalk beside the IWK just after 10:30 p.m. on June 15, 2016. Mr. Rogers' girlfriend was also present and she confirmed the dispatch reports that Mr. Rogers had been trying to enter the IWK. Ms. Spindler told the officers that her boyfriend was an alcoholic and needed to go to the "drunk tank".

[18] Mr. Rogers told police that he wanted to go home; however, the officers determined nobody was there so the decision was made to take him to the HRP Prisoner Care Facility (PCF), otherwise known as the cells. All three officers testified that they had the discretion to take Mr. Rogers to the PCF, home or to the hospital. As they believed that Mr. Rogers was not ill or unconscious, they saw no reason to take him to the hospital.

[19] Cst. Paris elaborated that it was Ms. Spindler's "idea" for Mr. Rogers to be taken to the cells rather than home, given that nobody was there. As for the option to go to the hospital, Cst. Paris "saw no reason for Mr. Rogers to be taken for medical assessment". The officers all testified that at all times when they interacted with him, Mr. Rogers was never unconscious and although he was agitated, they found him oriented and understood what he was saying. Throughout their dealings with him, the officers saw no requirement to call Emergency Health Services ("EHS") to attend to him.

[20] Mr. Rogers was arrested for public intoxication and at this point became uncooperative, resisting the officers' attempts to handcuff him and place him in the back of Cst. Morris' marked police vehicle. Ultimately, it took the three officers to handcuff Mr. Rogers and two of them to get him into the car. As Cst. Morris reported to his colleagues via radio during the short drive from the hospital to the police station on Gottingen Street, Mr. Rogers spat and banged his forehead on the "silent partner" plexiglass between the front and rear police car seats.

[21] Cst. Murphy (passenger in the police car driven by Cst. Paris) filled in a check sheet or an arrest screen with respect to Mr. Rogers. He noted that Mr. Rogers had been arrested for public intoxication under the *Liquor Control Act*, R.S.N.S., c. 260 (as amended) (*LCA*), such that the PCF booking officers would be aware (in advance of him arriving) that Mr. Rogers was an intoxicated person.

[22] Once at the station and on account of Mr. Rogers hitting his head during transport, Cst. Paris shone her flashlight on Mr. Rogers and did not observe injuries. She added that he was not complaining of any pain. The three officers gave consistent evidence that Mr. Rogers did not exhibit any injuries or illness.

[23] Once at the police station Mr. Rogers yelled, cursed and threatened the officers. There was a young offender being processed ahead of him so the officers had to wait before taking Mr. Rogers into the station for booking. There is video surveillance (contained within exhibit 10) showing Mr. Rogers' time at the police station/PCF from the time he enters until following his death. There is also audio for this period of time, albeit not all of what is said at the PCF can be heard. Transcripts of the discernible audio were filed as exhibits and I found them to be generally accurate.

[24] Given that Mr. Rogers was belligerent and spitting, Cst. Paris asked Cst. Murphy to obtain a spit hood from the booking area inside the station. Cst. Murphy did so and Cst. Paris placed the spit hood over Mr. Rogers' head. He was then asked to get out of the police car but he refused. As Mr. Rogers hooked his legs under the silent partner, it took all three officers to extract him from the vehicle. While special constable Gardner held the door open, the three officers carried Mr. Rogers into the booking area. As he laid on the floor adjacent to the booking desk Mr. Rogers' belt and shoes were removed. Mr. Rogers was searched and it was determined that he did not have any drugs on him.

[25] Mr. Rogers made it clear that he did not want to be in detention and refused to co-operate with the arresting and booking officers. Csts. Morris and Murphy dragged Mr. Rogers approximately 20 feet to cell number 5, a "dry cell". As the description suggests, this cell has no running water, toilet or even a bench. It is a small (approximately 4′ x 7′) concrete enclosure with an iron bar door. Cells 4 and 6 (they are not dry cells) are on either side of cell 5 and there is a small hallway outside of the three cells with bars (and a bar door) separating it from the main hallway. Mr. Rogers was placed on his stomach in the cell.

[26] The officers felt that Mr. Rogers was capable of walking but that he refused to do so. Cst. Murphy advised the booking officers that Mr. Rogers was "playing possum". Cst. Murphy elaborated in his testimony about what he meant; "my understanding that moments ago he was standing and talking …now he's playing possum, he's choosing not to walk". He added that he felt that Mr. Rogers was behaving this way intentionally, "because he's upset with us".

[27] It took the three officers to remove his handcuffs. The constables then exited the cell leaving Mr. Rogers laying on the floor. The spit hood was left on, over his head. The officers did not want to remove the spit hood as they were of the collective view that the agitated Mr. Rogers would likely spit on them. All were of the belief that (the now uncuffed) Mr. Rogers would remove the spit hood on his own.

[28] Cst. Paris allowed that if Mr. Rogers did not take off the spit hood, a booking officer might do so. She added that once the officers left, she understood that the booking officers would check on Mr. Rogers.

[29] Cst. Morris was last out of the cell. He left the spit hood on Mr. Rogers because to do otherwise would "defeat the purpose". He recalled telling Mr. Rogers to "sleep it off so he could see his kid in the morning and he told me to fuck off (or fuck you)". At the time Cst. Morris did not believe Mr. Rogers required medical attention. He had no concerns with Mr. Rogers being left in the cell with the spit hood on because he thought that he would remove it.

## **Booking Officer Gardner's Initial Interaction with Mr. Rogers**

[30] Cheryl Gardner testified that she considered the conversation that Mr. Rogers had in the booking area when she admitted him to the PCF. She was referred to exhibit 13, tab 7, the transcript of the audio from the video (exhibit 10) played in Court from the time when Mr. Rogers first entered the booking area. She said that the conversation allowed her to make the judgment call to accept Mr. Rogers for cells. She noted Mr. Rogers answered questions and she did not at any time believe that Mr. Rogers was extremely intoxicated. Ms. Gardner recalled that he did not have any licit or illicit drugs on him. Ms. Gardner placed Mr. Rogers in cells based on, "the things I observed, the things passed on by the officers …that Mr. Rogers could be aggressive and verbally combative and uncooperative".

[31] She knew from radio contact prior to their arrival that Mr. Rogers had been arrested "for 87" (public intoxication). She knew he drank liquor (but not how much) when he was arrested outside the IWK. Ms. Gardner was aware that he had acted

"aggressively" there. She did not notice any change in Mr. Rogers' behavior from the time he arrived at the PCF until he was placed in cell 5.

[32] Ms. Gardner agreed that generally when she observed a prisoner that it included looking at the person's face. With Mr. Rogers, she could not observe his face; however, she "…also had the officers' accounts, I knew he was drunk …he drank some alcohol before he came in". She heard Cst. Morris say this but she did not hear him say the amount of alcohol. On cross-examination she acknowledged that Cst. Morris said that Mr. Rogers "chugged half a pint". Although she does not recall this, she agreed that it would be an important consideration in how to deal with Mr. Rogers. She agreed that it was "common sense" that this factor, "might change a person's level of intoxication while in cells".

[33] Ms. Gardner said that "at least once a shift" booking officers deal with uncooperative prisoners. She elaborated that these prisoners do not follow directions and sometimes, "don't do anything at all". She said that it was not uncommon for individuals brought into the PCF to lay on the floor as Mr. Rogers did. Ms. Gardner felt that these prisoners were "purposely not doing as they're asked to do".

[34] In terms of cell assignment, noncombative men who have been arrested under the *LCA* are typically placed in one of the two large "drunk tanks". Combative prisoners are placed in one of the single cells, which could mean being placed in cell number 5, the dry cell. Ms. Gardner noted the dry cell was suitable for those who might harm themselves, others or cause property damage within the cell.

[35] Ms. Gardner knew all three officers who brought in Mr. Rogers. She thought them to be conscientious. Mr. Rogers was known to her as she had seen him in custody before. In terms of the cell choice for Mr. Rogers, she told Cst. Murphy that if Mr. Rogers was not being cooperative that he should be placed in cell 5. It was put to her on cross-examination that Mr. Rogers "earned" his cell placement; however, she denied this.

[36] Ms. Gardner referred to exhibit 6, the prisoner medical information form. She said this form was designed to give booking officers "an idea if there were any medical concerns with the prisoner, they don't have to answer, most intoxicated prisoners don't answer". She recalled calling out Mr. Rogers' name to answer when he was laying on the floor in the main booking area. She typed in "too intoxicated to answer" a "general answer, whether they are or not". As for the last question, she answered "booking officers' observations" with, "no visible signs of injury or

medical distress" based on, "what I saw of Mr. Rogers in the main booking area before he went into cells".

[37] On cross-examination she said that she tried to ask Mr. Rogers the questions on the form. Ms. Gardner said she was "certain" about this; however, it was pointed out that the audio on the video does not indicate this and her alleged word(s) do not appear on the transcript (exhibit 13, tab 7). Her transcribed comments are:

| **Recorded Time** | **Quote** |
|---|---|
| 11:06:10 | Belt? Laces? |
| 11:08:55 | Put in 5? |
| 11:09:50 | Role model father right there |

[38] It was put to Ms. Gardner that none of the officers told her that Mr. Rogers was not answering questions; however, she maintained that she was told this.

[39] Ms. Gardner observed that Mr. Rogers was "drunk". She recalled that one of the officers said as he was coming through the booking door that Mr. Rogers was "playing possum". She took this to mean that he was refusing to walk.

[40] Ms. Gardner observed that Mr. Rogers and the officers were having conversation. She did not detect any unresponsiveness or signs of illness. She did not classify Mr. Rogers as "extremely intoxicated". In her view, this would be someone unable to keep their eyes open or respond appropriately. Such an individual might have been reported as having been passed out. With an extremely intoxicated person Ms. Gardner would call EHS in to assess.

[41] On cross-examination she said "possum" was the word used by the officers and that she believed them. It was put to her that she did not question Mr. Rogers and based her decision "one hundred percent" on what the officers said. Ms. Gardner denied this, stating "he was making noises in the booking area, he was answering questions, moaning and groaning". She added that there were signs that he was drunk, she knew he had hit his head on the silent partner and that he had been kicked out of the IWK for being drunk.

[42] Ms. Gardner stated that on some occasions she called EHS to attend to intoxicated prisoners. About half of her decision is based on what the officers tell

her and the other half on her observations. Later she added that the "some" of the decision is based on "previous experience with the person being brought in". She had prior experience admitting Mr. Rogers to the PCF. She termed the decision to admit or deny a judgment call.

[43] Ms. Gardner confirmed that there were four prisoners in custody on the night in question. She described it as a "steady night", noting her responsibilities beyond prisoner care. She agreed that Mr. Rogers was the only prisoner placed in a dry cell and the only one who was carried in and wearing a spit hood.

**Csts. Paris' and Murphy's Experience in the PCF**

[44] In June, 2016, Cst. Paris had over ten years with HPD. During her time as a police officer, she had some experience working in the PCF. She learned on the job from the booking officers. From her experience, a prisoner in a cell was to be checked on every 15 minutes, "to make sure they don't need anything, that they're o.k.". She recalled on one prior occasion observing a prisoner with a spit hood on, albeit, the person was seated in a restraint chair. Cst. Paris had never before seen a prisoner wearing a spit hood laying face down in a cell.

[45] Cst. Paris testified that she is now familiar with what are known as the "4 Rs". She described this "rousability check" as "part of policy". On cross-examination she agreed that the police service provided "no real guidelines" on checking on prisoners in the PCF. Prior to the events involving Mr. Rogers, she had "no idea" about the 4 R check.

[46] When checking on prisoners, Cst. Paris would commonly see them sleeping. Rather than waking them up, she would ascertain if they were breathing. She might observe this or hear the person snoring. If she encountered an unresponsive prisoner she would immediately call EHS, her supervisor or seek assistance from another officer.

[47] Rather than opening the cell door it was her practice to reach in and wiggle a prisoner's toes with her hand or her baton. For security reasons – "prisoners can get violent" – she said that it was her practice not to go into a cell alone. On cross-examination she agreed that only in exceptional circumstances would she enter a cell alone with a prisoner inside. She added, "in fact, I never went in by myself".

[48] Cst. Murphy spoke of his experience with another booking officer, Stephan Longtin. He said that Mr. Longtin had a "CYA, overly cautious approach" in that he

would always call in EHS when an intoxicated person arrived at the PCF. He recalled that when special constable Longtin was working that he would have to wait at the PCF with the prisoner until the EHS supervisor arrived.

[49] Cst. Murphy understood that there were 12 PCF booking officers and that there would be a minimum of two on per shift. On cross-examination he agreed that Mr. Longtin's rule was personal to him and that other officers may have different rules. On further cross-examination he acknowledged that this was not a "rule" but rather, the way Mr. Longtin worked. Cst. Murphy added, "he wouldn't accept prisoners when they couldn't or wouldn't walk".

**PCF – Further Background**

[50] Staff Sgt. Mike Willett was the Non-commissioned Officer (NCO) for the PCF between 2010 and 2012. As such, he is familiar with the policy manual (exhibit 4) and medical questionnaire (exhibit 6). He noted policies were updated over time and could not be certain if "our" exhibits were in place during his tenure.

[51] When S/Sgt Willett was in charge of the PCF he would enter the facility at least once per shift. If there was an incident, he would be notified. He had seen spit hoods used while transporting a prisoner in a police vehicle and when individuals were brought into booking. He also observed spit hoods used on prisoners placed in restraint chairs. He never saw a spit hood put on a prisoner placed in cells.

[52] Based on his roughly two years of experience, S/Sgt Willett is familiar with cell checks. These were to be carried out every 15 minutes. When doing a cell check it would take five to ten seconds to monitor a prisoner for breathing. If it was not apparent that the prisoner was breathing, S/Sgt. Willett's practice was to open the cell and attempt to rouse the person. He entered his checks in a hand written log in the booking area. He learned these practices on the job.

[53] S/Sgt. Willett recalled cell 5 as a dry cell used for persons at risk for harming themselves or if they were "completely unruly, acting out". He thought the cell would have been used by times for intoxicated prisoners. He does not have familiarity with the 4 Rs and understood that "they came in later".

[54] Pursuant to *Criminal Code* s. 652, on the afternoon of March 15, 2022 the Court took a view of the PCF. This was at the request of all parties and at the Court's initiative the nearly eight minute tour was videotaped. Serious Incident Response

Team (SIRT) officer Luc Côté videoed the tour and was called as a witness for the sole purpose of introducing the video of the view as exhibit 12.

**SIRT Investigation**

[55] Keith Stothart retired from SIRT just over a year ago. A former RCMP officer, he became involved in this matter as part of a SIRT investigation. Whenever a person dies in police custody, SIRT is notified and carries out an investigation.

[56] Mr. Stothart reviewed the exhibits he seized (corresponding with the exhibits introduced at this trial), namely:

3 New Spit Hood – Control Sample (contained in clear plastic wrapping)

6 Prisoner Medical Form

7 Tranzport Hood Instructions

8 Cell Check Report

9 Criminal History Report – Corey Rogers

10 Hard drive containing:

- File folder entitled "HRP Cells"
- Corey Rogers Video Timeline
- Transcript of previous trial testimony – Cst. Pothier
- Transcript of previous trial testimony – Derek Jefferson
- Transcript of previous trial testimony – Emilie Spindler
- Transcript of previous trial testimony – James Diab
- Transcript of previous trial testimony – Michelle Regan
- Transcript of previous trial testimony – Ron Johnstone
- Transcript of previous trial testimony – Sgt. Wood
- Video of Dispatch Desk
- Video of Women's Loop
- NSLC – Sangster Report
- Report of Inspector C. Martin

13 Transcript of video footage and timelines

[57] During Mr. Stothart's evidence several of the videos within exhibit 10 were played in Court. I subsequently reviewed the other videos within the exhibit. Based

on my review of the videos, I find Mr. Stothart's transcripts to be a largely accurate description of the events in question. I also found that his capturing of the available audio (specifically at the PCF) to be accurate.

**The Spit Hood**

[58] As reviewed by Mr. Stothard, exhibit 7 is the label for the spit hood in question and the front reads:

> The Tranzport Hood™ is a temporary protective for use on those persons where a risk of exposure to infectious disease is present. If used properly, the Tranzport Hood™ can reduce the risk of the wearer transmitting fluids (saliva and mucous) from the facial area, as by spitting, sneezing or coughing. Improper use may result in serious injury or death due to asphyxiation, suffocation or drowning in ones own fluids
>
> CONDITIONS FOR USE:
>
> Do NOT use this product unless:
>
> - Prisoner is under control and restrained
> - Wearer must be under constant visual supervision and should NEVER be left unattended.
> - DO NOT USE on anyone that is vomiting, having difficulty breathing, or is bleeding profusely from the area around the mouth or nose.
> - Remove prisoner's jewelry and eyewear before application.
> - If there is difficulty applying due to large size head, discontinue use.

[59] Cst. Paris described the spit hood that she placed on Mr. Rogers as being mesh on top with "bendy cloth" on the bottom. She previously deployed spit hoods on a few occasions. During these times she placed the spit hood on the person but had never taken it off. She previously saw spit hoods used but only when a person was placed in a restraint chair. In this situation the prisoner would not have the ability to remove the spit hood on their own.

[60] On cross-examination Cst. Paris said that it was her "expectation" that a person in cells would take a spit hood off on their own. Specifically, she expected Mr. Rogers would take his off and not one of the booking officers.

[61] Cst. Paris elaborated on cross-examination as to why she felt the need to use the spit hood. She felt at risk of being spat upon by Mr. Rogers. If this occurred, she noted that she would need to go to the hospital. There would have to be a consent or

a warrant to obtain the prisoner's bloodwork. The entire situation would be "very stressful" and she wanted to avoid the possibility. She noted spit hoods could be commonly used and that some officers kept spit hoods with them while on patrol.

[62] Cst. Paris had no training on the use of spit hoods and had been told that it "was not a dangerous item". Asked about a spit hood policy she responded, "there was no policy".

[63] Cst. Murphy agreed with Cst. Paris that the spit hood was required for Mr. Rogers. The one he obtained from behind the booking counter was the same type as he had previously used. Cst. Murphy noted that he did not have one with him but that it was routine to have one when part of the "paddy wagon" patrol.

[64] Cst. Murphy had been spit on earlier in his career. He noted that the spit hoods he had used over the years ("at least ten times") came with "instructions on them". He recalled that you were not supposed to use the item if there was, "active vomiting, profuse bleeding or [if the prisoner was] left unattended".

[65] On cross-examination Cst. Murphy agreed that there was no spit hood training or policy. He stated that over the years he had seen a "couple of variations" of the (exhibit 7) spit hood instructions. The instructions advised that it could be dangerous to leave a person wearing a spit hood unattended; however, he did not relay this to Csts. Morris, Paris or the booking officers. On further cross-examination Cst. Murphy clarified that it was not until after this incident that he read the instructions. He added that he was not concerned when Mr. Rogers was left with the spit hood on.

[66] On cross-examination Cst. Murphy said that he had never before removed a prisoner's spit hood in a cell. He recalled on all occasions that the prisoner, and not the police or booking officer, would pull it off. He expected the same with Mr. Rogers. He had no concerns leaving Mr. Rogers with the spit hood on, noting that he was conscious, had sworn at the officers and re-positioned himself in the cell.

[67] Cst. Morris stated on cross-examination that there is potential to contract a communicable disease such as hepatitis C or HIV from saliva. Although they had "a conversation" while in the back seat, Mr. Rogers "chose to continue to spit". He added that on one prior occasion at the PCF he assisted with putting a prisoner in a cell who had a spit hood placed over him. He recalled that the officers left the spit hood on and "the individual took it off once he was in the prone position", adding that he expected Mr. Rogers to do the same. Cst. Morris stated that it was only in the

context of a prisoner in a restraint chair that he would have observed an officer removing a spit hood.

[68] Ms. Gardner said that she was familiar with spit hoods, having provided them (from stores) to police officers. She also recalled a couple of occasions assisting officers by placing a spit hood over a prisoner's head. At the relevant time she had not read the spit hood instructions. She noted that the instructions were on "a piece of paper, rolled up, I hadn't paid much attention". Ms. Gardner was of the understanding that once a spit hood was placed on a prisoner "that it stayed on the prisoner …the prisoner would remove their own spit hood". She was unaware that a spit hood could cause injury or death. She was never told that it was her responsibility to remove a spit hood. Ms. Gardner had no training on the use of spit hoods. She was unaware of the spit hood policy.

[69] Ms. Gardner knew Mr. Rogers had the spit hood on when she checked on him. She never thought of removing it and was not told to do this. She believed that a person could breathe while wearing a spit hood.

**The PCF Internal Oversight Sergeant**

[70] In June, 2016 Sgt. Stephen Gillett was in charge of auditing the PCF booking office. This "internal oversight" involved a review of the policies and procedures. Sgt. Gillett examined the videotape from the night of June 15th and early morning hours of June 16th. He also reviewed the relevant booking history.

[71] Sgt. Gillett explained his familiarity with the booking office policies and procedures. He noted that Mr. Rogers was at the PCF on account of his arrest for public intoxication. He stated that as soon as the decision was made by the booking officers to accept the prisoner, "he becomes the responsibility of the booking officers". He added that the booking officers "determine if the individual is fit for cells".

[72] In terms of the assessment of Mr. Rogers, Sgt. Gillett noted that there had been a conversation between the booking officers and the arresting officers. Exhibit 6 was referenced, the prisoner medical information form. Sgt. Gillett noted that the questionnaire is "voluntary, for the prisoner to answer". Given that Mr. Rogers was too intoxicated to answer, Sgt. Gillett said, "he should not have been taken into the cells, he should be assessed by medical, put in a holding cell and monitored".

[73] Sgt. Gillett noted that Mr. Rogers was carried in and laid on the floor of the cell. Referencing the "Glasgow Coma Scale" he said that when someone is laid down, "he needs medical care". Based on his review of the video surveillance and cell check report (exhibit 8), Sgt. Gillett did not believe there were physical checks of Mr. Rogers.

[74] Sgt. Gillett agreed that a police officer could be brought in to assist booking officers in the PCF. He said that June 15/16 was "not a busy night". He recalled one other dry cell prisoner and no other high risk prisoners. Neither of the booking officers called watch command seeking assistance.

[75] He agreed that the booking officer has a great deal of discretion including whether or not to accept a prisoner into their care. He testified that booking officers' duties include: carrying out prisoner searches, finger-printing and photographing, preparing recognizance documents and the like, logging and storing property, ensuring prisoners take their medication, dealing with injuries, answering the phone, dealing with the RCMP, arranging transport, methadone treatment, meals, handling young offenders, escorting prisoners to speak with lawyers, dealing with EHS, preparing cell sheets, checking warrants and making computer entries. In the result, he agreed that a booking officer could, even without a high volume of prisoners, be considered busy.

[76] Having reviewed the video and documents, Sgt. Gillett stated that the first and second checks of Mr. Rogers did not involve the 4 Rs. He said that the booking officers were made aware of the 4 Rs; they had training and there was a large poster in the booking area outlining the 4 Rs. The wording on the poster is consistent with what appears at Appendix B of exhibit 4, the June 6, 2012 "Orders To All Ranks" letter signed by (then) HRP Chief Frank A. Beazley attaching the standard operational policy and procedure on custodial care of prisoners:

| Rousability |
| --- |
| *Can they be woken?*<br>• Go into the cell.<br>• Call their name.<br>• Shake gently. |

| Response to questions |
| --- |
| *Can they give appropriate answers to questions, such as:*<br>• What's your name?<br>• Where do you live?<br>• Where do you think you are? |

**Response to commands**

*Can they respond appropriately to commands, such as:*

- Open your eyes!
- Lift one arm, now the other arm!

**Remember**

*Take into account the possibility or presence of other illnesses, injury, or mental condition.*

A person who is drowsy and smells of alcohol may also have the following:

- Diabetes
- Epilepsy
- Head injury
- Drug intoxication or overdose
- Stroke

**If in doubt, call an ambulance!**

[77] According to Sgt. Gillett, Mr. Rogers' spit hood should have been removed. He elaborated; "common sense and the packaging …a prisoner with a spit hood on should not be left unchecked". If the spit hood was not removed then Sgt. Gillett stated that "a rigorous 4 R check" needed to be done by two officers "for safety reasons". He went on to say that the initial check should have included removing the spit hood and carrying out the 4 Rs, namely: responding to questions, responding to commands, breathing and remembering other medical conditions.

[78] In 2016 if a prisoner was considered "high risk" then 4 R checks were required. He described the checks as determining "rousability". He said these checks should be done on an intoxicated prisoner every 15 minutes, adding that "you don't have to go in the cell every 15 minutes".

[79] On cross-examination Sgt. Gillett confirmed that a 4 R check can be done from outside the cell and that if the prisoner responds to the initial question that this fulfills all 4 R requirements.

[80] Sgt. Gillett noted that prisoners represent different levels of risk. A sober prisoner would be considered low risk. High risk prisoners have one or more of these characteristics: highly intoxicated, suicidal, injured, significant medical conditions.

[81] Sgt. Gillett stated that an intoxicated or highly intoxicated person with no other risk factors can still be high risk. He spoke of checking on such individuals by questioning them and/or observing them breathing.

[82] Sgt. Gillett noted that Mr. Rogers was accepted without a medical assessment. He confirmed that Mr. Rogers was left in cell 5 with the spit hood left on. He added that he had not seen this happen before with a prisoner, and, "that prisoner needs to be assessed as to the 4 Rs …if they don't respond to questions, they [booking officers] need to go into cells to physically assess, this was not done here."

[83] Sgt. Gillett agreed on cross-examination that Mr. Rogers was carried into the cells because he refused to co-operate. He agreed that some prisoners "play possum" and that the booking officers were told this about Mr. Rogers by an arresting officer.

[84] Sgt. Gillett testified that if a person does not respond to a 4 R check then a medical assistance call needs to be made. If a prisoner (not deemed high risk) is unresponsive, then a booking officer should enter the cell to render assistance. This would be a "game time" decision with Sgt. Gillett adding that the booking officers should have their portable radios on to radio for assistance.

[85] Sgt. Gillett stated that there was a booking officer policy (exhibit 4) at the material time. He noted that the policy was readily accessible, online. When hired booking officers were shown the policy and told, "in effect, this is what your job will be".

[86] When Mr. Rogers was brought in to the PCF, Sgt. Gillett stated that it was not short staffed. Two booking officers were on duty but when one went on lunch, this would mean one left on duty. On cross-examination he acknowledged that there were a number of complaints lodged by booking officers (and specifically special constables Fraser and Longtin) regarding the 4 R checks. He took these concerns to management but never received a response. In turn, Sgt. Gillett advised the booking officers that he was aware of the concerns and that they should "do the best that you can". On cross-examination Sgt. Gillett said he was aware that a significant portion of 4 R checks were not being done.

[87] He acknowledged that the booking officers asked for more officers for shifts but that this was declined. He agreed the booking officers' main complainant was an understaffed PCF. Given the lack of response to the booking officers' concerns, he allowed, "we set these people up to fail".

[88] On cross-examination, Sgt. Gillett agreed that it was the duty of the PCF duty sergeant to do prisoner rounds; however, this did not occur, "a problem there". He agreed that it was the sergeant's duty to advise a booking officer if they were doing

anything wrong and that he never received any complaints about either of the accused booking officers.

[89] On cross-examination Sgt. Gillett agreed that during the entire period that he supervised special constables Gardner and Fraser he never had anything negative brought to his attention. Indeed, he described both special constables as "very kind with our prisoners, they took care of them. They were very, very competent".

[90] With respect to possible police officer assistance in the PCF, Sgt. Gillett agreed that the NCO has been historically reluctant to take officers "off the street" to assist. On cross-examination he agreed that if a prisoner responds to a booking officer's command that this satisfies the 4 R requirements. He agreed that booking officers are instructed not to wake sleeping prisoners, as long as they are not high risk. He agreed that whether a prisoner is high risk falls within the judgment of the booking officer.

[91] Sgt. Gillett acknowledged that management had never advised booking officers that spit hoods could be dangerous. As at June, 2016 he admitted that there was no spit hood training. He acknowledged that the booking officers received no guidance on how to use spit hoods; that they were not advised on how and when to remove them. On cross-examination he was referred to the only spit hood policy, 2.7 B 7, (within exhibit 4) which reads:

> 7. Spit hoods will be placed on a prisoner prior to beginning the process of securing him/her in the Chair. Upon removal of a hood from a prisoner, the booking officer shall dispose of same.

[92] On cross-examination Sgt. Gillett agreed that his opinion (formed after the fact) of Mr. Rogers being high risk, differed from the classification of the booking officers. He agreed that not all intoxicated persons are high risk. He admitted that the video did not provide complete information and "I don't have all the pieces of the puzzle". He acknowledged that if Mr. Rogers was not deemed high risk the level of care afforded to him diminished. Based on the "sliver of information" (his viewing of the video), Sgt. Gillett would not have admitted Mr. Rogers.

[93] On cross-examination Sgt. Gillett explained that there are monitors above the booking desk. At the time he thought the monitor was 32″ x 38″. He explained that the small squares could be "blown up"; however, it was very difficult to observe subtle movement on the poor pixel quality monitors.

**Cheryl Gardner**

[94] Ms. Gardner is 49 years of age. She has a grade 12 education and a certificate in the Corrections and Policing program at Success College.

[95] Mr. Gardner's initial employment with HRP was as a clerk in quarter master stores. Her job duties involved issuing uniforms and equipment. In around 2010 Ms. Gardner became a booking officer or booking technician, the position she held at the time of the matter that forms the basis for the criminal charge.

[96] Before assuming the job as a booking officer, Ms. Gardner received two weeks of training. Ms. Gardner recalled that senior booking officer, Stephan Longtin taught Versadex, processing documentation, the *Criminal Code* along with general training.

[97] On cross-examination she agreed that Mr. Longtin's policy that if a prisoner did not walk in on their own, they do not stay at the PCF was a "really safe policy". She added on further questioning that the initial cell check was important to monitor if the prisoner's condition is worsening. When it was put to her that she could have walked out to where Mr. Rogers was when he first came in, she replied that "Sgt. Gillett does not like us to be on the prisoner side".

[98] When she started at the PCF Ms. Gardner was assigned to job shadow other booking officers. This lasted for a month or two and she recalled taking fingerprints and photographs as well as learning how to serve documents. Ms. Gardner also received cell check training which involved checking to make sure that those in cells were okay. Ms. Gardner testified that she did not receive any training with respect to the affects of alcohol on the body.

[99] Ms. Gardner went over her job duties during the course of her six years as a booking officer, including:

- processing individuals arrested and brought into the PCF by police
- preparing, processing and serving documents
- fingerprinting and photographing
- monitoring prisoners in cells
- in certain instances, conducting hearings for remand and the like, sometimes away from the PCF

- securing cash bail
- making entries in the booking log
- ensuring prisoners received required medication including methadone
- when required, arranging for EHS paramedics to attend the PCF
- arranging prisoner transport
- general paperwork and computer entry
- utilization of the Versadex system
- facilitating requested prisoner calls to lawyers

[100] Ms. Gardner testified that she never received a complaint or negative comment on her work performance from her supervisors. She added that she was never corrected on her cell checks by her NCO. Later she stated that her NCO/Sgt. never questioned her regarding any 4 R checks she did or did not do.

[101] Ms. Gardner reviewed the routine involved when receiving a prisoner at the PCF. After police officers search the prisoner, the booking officer takes, logs and stores their personal property. If the person is arrested for an indictable offence, they are finger printed and photographed. Documents are prepared and certain information is entered into the Versadex system.

[102] Ms. Gardner acknowledged that it is the booking officer's duty to determine a prisoner's fitness for being placed in cells. She testified that it is a judgment call based on the booking officer's observations and information received from the arresting officers. She noted that police spend more time with the prisoner. The police invariably report obvious signs of injury, illness or level of consciousness.

[103] Ms. Gardner was taken to exhibit 4, noting that her supervisor, "never sat me down to go over these policies". She added that her superiors said that "policies are a guideline, if we could not follow and justify why, it would be okay". On cross-examination she acknowledged exhibit 4 to be a "routine order, not to be ignored". Ms. Gardner said that the 4 Rs can be done outside the cell area and "only if certain things do you go in".

[104] With respect to Mr. Rogers, Ms. Gardner said she complied with policy 6.7, acknowledging that upon taking the prisoner to the cell, he became her responsibility. She stated that she answered to the NCO and that once per shift the NCO would attend at the PCF and individually carry out a prisoner check.

[105] By 2016, Ms. Gardner worked both night and day shifts at the PCF. She was referred to various sections within exhibit 4 including 7.7 A and B which read:

> 7. Account for and check the condition of all prisoners:
>
> A. For the first cell check both the incoming and outgoing officers will complete the check together. It shall include inspections of empty cells, large cells, keys, locks, the holding cell, and both restraint chairs.
>
> B. The first cell check shall include the 4 Rs.
>
> **Note: The progressive check need not begin again at the start of the incoming booking officer's shift and may carry over in accordance with the outgoing booking officer's instructions on the condition of each prisoner.

She responded that "this was done", adding that 4 R checks took place on all prisoners on shift change when one booking officer was going off shift and the other coming on. She noted that if the booking officers had to enter a prisoner's cell that this could be done safely when there were two booking officers.

[106] Ms. Gardner said that ordinarily when two booking officers were working, one would do cell checks. Since it was "too dangerous" for one booking officer to enter the cell, 4 R checks were not done during those cell checks. She elaborated that one never went into cells alone because, "we don't know if the prisoner is going to be ready to attack".

[107] Ms. Gardner was referred to policy 7.3 A, B and C referable to the duties of "Sergeants detailed to the PCF…". In keeping with the policy she stated that Sergeants would be present on the limited weekend hours "between 01:00 and 05:00 or a Friday or Saturday night shift", the "high volume nights". According to Ms. Gardner, the Sergeants would do cell checks without the booking officers present – "we'd be at our work stations". She could not say if the Sergeants did 4 R checks.

[108] Ms. Gardner was referred to policy 2.1 and this provision:

> <u>B. BOOKING OFFICER</u>
>
> 1. During each shift, the booking officer shall monitor all prisoners and:
>
> a. Ensure the safekeeping of all persons in custody. Check the welfare and condition of each prisoner by:
>
> i. personally attending the Detention Area at least every 15 minutes. Reliance on camera monitors is not adequate. The

> booking officer should be in possession of a Detention Area key an the approved cutting tool during these checks. Utilize the Arousability Chart during the check. If a prisoner is not arounsable or is unable to remain awake after being aroused, place him/her in a recovery position until s/he receives an emergency medical evaluation in accordance with **INJURED, ILL or UNCONSCIOUS PRISONERS**. If the prisoner shows no signs of improvement and increased arousability 3 hours after the initial evaluation, contact IES and request an ambulance attend booking in accordance with **INJURED, ILL or UNCONSCIOUS PRISONERS**;
>
> ii. detailing the physical and medical condition of each prisoner in the appropriate log book after each visit. Entries such as, "All in order" do not meet the required standard;
>
> iii. record the condition of the Detention Area and the exact time each check was performed in the appropriate log book maintained by the booking officers for this purpose.

She noted that Mr. Rogers was in their custody for less than three hours on June 15/16, 2016.

[109] As for conducting the 4 R checks every 15 minutes, "it's not very realistic because it takes time to wake and have them answer questions and then move on to others". In the result, she said that the prisoner checks would be done every 20 to 25 minutes.

[110] Once cell checks are completed, Ms. Gardner's practice was to return to her desk and make entry of the check into the Versadex system and re-set the (15 minute) timer (bell goes off to alert the booking officer).

[111] Ms. Gardner recalled that on one occasion when she performed a cell check with another booking officer, she entered the cell and had to resist a prisoner. The man tried to hit her with his fist but she blocked him and got outside of the cell.

[112] Considerable time was spent on cross-examination reviewing exhibit 4. She acknowledged that the June 6, 2012 cover letter was signed by then HPD Chief Frank Beazley and that it was titled "Orders To All Ranks". While acknowledging that the orders "were not optional" she explained that they were carried out "to the best of our ability". Ms. Gardner agreed that it was fairly simple to follow the 4 Rs. She admitted that entering a log check when one did not occur was impermissible.

[113] Ms. Gardner said that her cell checks involved looking to make sure the prisoner was breathing and not showing any sign of distress or injury. Referred to the part of the policy regarding booking officers being permitted to request additional assistance, she answered that she had made requests to the Sergeant. She described the process as, "…a fight, we had to justify why we needed that person to come in. They didn't want to take police officers off the street". She added that they often would not receive assistance or if they did that booking officers would wait "quite awhile" for assistance to arrive.

[114] Ms. Gardner was referred to the policy regarding intoxicated and extremely intoxicated prisoners. With respect to extremely intoxicated persons she noted that the policy says they "may" warrant medical attention. She elaborated, "it's a judgment call I would make based on what I observe in the main booking area, what I'm told by the police officer and any other observations of signs of illness…"

[115] Ms. Gardner said that EHS should be called when they have a person unfit for cells. Having said this, she stated that she does not have any training in this area.

[116] On the evening of June 15 and early morning of June 16, 2016, Ms. Gardner explained how she processed another prisoner just after midnight. The fellow can be observed being brought in by a police officer on the video. She noted that she was situated behind the booking counter and called EHS as the prisoner was diabetic and needed medication. Ms. Gardner also received his property and shortly thereafter went on a cell check. On cross-examination she acknowledged the night in question to be "steady".

[117] Ms. Gardner was referred to exhibit 8, the cell check report documenting entries regarding Mr. Rogers. Below I have set out the relevant information from this document:

| Check Time | Check By | Cell Okay | Remarks | Entry Time | Entered By |
|---|---|---|---|---|---|
| … | … | … | … | … | … |
| 2319 | FRASER,DAN | YES | PRISONERS CHECKED | 2319 | GARDNER,CHERYL |
| … | … | … | … | … | … |
| 2337 | GARDNER,CHERYL | YES | LAYING ON FLOOR/BREATHING | 2337 | GARDNER,CHERYL |
| … | … | … | … | … | … |
| 0002 | GARDNER,CHERYL | YES | LAYING ON FLOOR/SLEEPING/ BREATHING | 0002 | GARDNER,CHERYL |
| … | … | … | … | … | … |
| 0023 | GARDNER,CHERYL | YES | SLEEPING ON FLOOR | 0023 | GARDNER,CHERYL |
| … | … | … | … | … | … |
| 0041 | GARDNER,CHERYL | YES | LAYING ON FLOOR/SLEEPING | 0041 | GARDNER,CHERYL |
| … | … | … | … | … | … |
| 0055 | FRASER,DAN | YES | RESTING/BREATHING | 0133 | FRASER,DAN |
| … | … | … | … | … | … |
| 0111 | FRASER,DAN | YES | RESTING/BREATHING | 0134 | FRASER,DAN |

| | | | | | |
|---|---|---|---|---|---|
| … | … | … | … | … | … |
| 0125 | FRASER,DAN | YES | RESTING/BREATHING | 0134 | FRASER,DAN |
| … | … | … | … | … | … |
| 0217 | GARDNER,CHERYL | YES | DECEASED | 0217 | GARDNER,CHERYL |
| … | … | … | … | … | … |
| 0228 | GARDNER,CHERYL | YES | CHECKS SUSPENDED AS PER SGT ROBINSON | 0228 | GARDNER,CHERYL |
| … | … | … | … | … | … |

[118] Ms. Gardner said that once the cell checks (for Mr. Rogers as well as five other prisoners) were complete, the cell number and her observations were entered. As with the initial check on Mr. Rogers, she noted the check could be made by one booking officer and entered by another. As with most of the entries above, it was generally not uncommon for the entry time to differ from cell check time.

[119] Ms. Gardner stated that she remembered her checks of Mr. Rogers. During her first check at 11:37, "I had gone to his cell, called his name to get his attention, he was making noises and moving his shoulder".

[120] On cross-examination, she said that she would not enter Mr. Rogers' cell alone because he was too intoxicated. Ms. Gardner agreed the first check was roughly 11 minutes after Mr. Rogers had been placed in the cell. She agreed that Mr. Fraser did not enter Mr. Rogers' cell. Ms. Gardner's next check was 21 or 22 minutes after the first check. She started the 4 R check by calling Mr. Rogers' name but agreed that she did not complete the rest of the 4 Rs. She said he "moaned and moved his shoulder, I took it that he acknowledged my presence but didn't want to answer me". She did not enter his cell. She said that because he moved after his name was called that she took it as a "verbal response". When it was put to her that she walked away without checking to see if he could respond to questions, she agreed but added; "yes, but as he's not being cooperative, I didn't expect him to try." Alarm bells were not raised because she thought he was acting in this manner on purpose.

[121] Ms. Gardner admitted that it is important to look for the prisoner's level of consciousness. Asked how she could do this when the person's face was covered, she replied; "he was breathing, I could see his shoulder moving, I took as his response to me". She agreed that since she could not see his face, she would not know if he had thrown up.

[122] On cross-examination she agreed that since Mr. Rogers did not remove his spit hood that it might be a sign that he was unconscious. She then elaborated that she was aware of prisoners that had fallen asleep for a couple of hours with a spit hood on. When it was put to her that she had never provided this evidence before, Mr. Gardner said that she meant it would not be an impossibility.

[123] The next check she made was at 12:02 on June 16th; "I went to the cell, I called his name, banged on the door, he didn't react, I could see he was breathing". For her next check at 12:23, "I went up to the cell door and I could see he was lying on his side breathing, sleeping on the floor". As for the 4 Rs, "I did not ask any questions or anything, no".

[124] On cross-examination Ms. Gardner was taken to her second check which she agreed happened 23 – 24 minutes after her first check. When it was put to her that she did not even start a 4 R check, she replied, "I banged on bars". Although Mr. Rogers did not wake up or respond, "…he was breathing so I took it as sleeping and left him to sleep. She admitted that because his spit hood was on that she could not see his face, including whether his eyes were open or his nose plugged. She was reminded of her jury trial evidence where she agreed that she would never leave someone who was drunk with a spit hood on alone in her own home.

[125] Ms. Gardner said that Mr. Fraser went for his lunch break at about midnight. In the result, she was the sole booking officer on duty during most of her checks of Mr. Rogers. When they were both on duty Ms. Gardner said, "our practice was the same as across the board with two booking officers working, one would be behind the desk … the other would do cell checks".

[126] Exhibit 8 shows the cell check as occurring (and entered) at 12:23 for Mr. Rogers with the remarks, "sleeping on floor". On the video Ms. Gardner can be seen entering the small vestibule outside of cells 4, 5 and 6. It is apparent from the video that Ms. Gardner is obviously looking into the area where the cells are located (and the record confirms that nobody was in the other two cells). Ms. Gardner recalled that Mr. Rogers "appeared to be sleeping". She added that she went up to his cell door. Ms. Gardner said that she made noise against the bars of the cells and that she could tell that he was sleeping and breathing.

[127] On cross-examination Ms. Gardner agreed that her third check actually occurred at 12:21. She agreed that her note says nothing about breathing adding, "I'm certainly not perfect …he appeared to be sleeping to me". She agreed that she was supposed to do a 4 R check but that she did not see if she could wake him up.

[128] Mr. Gardner checked on the other prisoners and returned to the booking area to finish processing the diabetic prisoner. While watching the video, Ms. Gardner described the tasks she completed, noting that she was alone on duty. She noted that her call to EHS was around 12:20 and that the paramedic arrived about 15 minutes

later. Ms. Gardner confirmed that she watched the entrance to the booking area and gave EHS (and others) access.

[129] While watching the video (12:13 – 1:20 played in Court) Ms. Gardner addressed the audible background noises. She note that the ringing was the cell check timer; the chime was for the doorbell and that the phone ringing came from her desk phone.

[130] Ms. Gardner addressed her last cell check of Mr. Rogers before she went on her lunch break (entry and check times of 12:41). As shown above, the remarks on exhibit 8 for this entry read: "laying on floor/sleeping". On the video she can be seen carrying items which she identified as a blanket and protein bar which she took to a prisoner. She testified that when she went by cell 5 that she "looked in to see if there was any sign of distress". She also described her other checks; e.g., "I glanced in at the tank, to check on a prisoner as I went by". She said that based on her checks of Mr. Rogers that no alarm bells were raised.

[131] On cross-examination Ms. Gardner confirmed that it was more than 15 minutes between checks when she did her fourth check. She explained that booking officers were told to do the checks every 15 minutes but that the interval could be long, "… the best we can … we try to adhere to it but we don't do perfectly". On this occasion she also did not carry out a 4 R check.

[132] In terms of her interactions with Mr. Rogers, while he was in the cell, she acknowledged that she did not have any conversation with him. She said that she thought he was sleeping; however, she admitted that she could not tell if he was sleeping or unconscious. She elaborated that because Mr. Rogers was breathing, that she believed he was sleeping. Later Ms. Gardner added that she saw him moving around. Since he had the spit hood on, she agreed that she could not detect any facial expressions or responses. She also acknowledged that she could not have observed if he vomited.

[133] Ms. Gardner agreed that had she been in doubt about Mr. Rogers' condition that she could have called an ambulance. She agreed that she had called EHS many times before and had done so on the evening in question.

[134] On cross-examination she acknowledged saying that she thought Mr. Rogers had "pooped himself", but that she did not know when. She further agreed that it was not uncommon for PCF prisoners to defecate, but that she did not get care for Mr. Rogers then or subsequently perform a 4 R check.

[135] Ms. Gardner can be seen returning to the main booking area after these checks. At this point the paramedic is attending to the diabetic prisoner and Ms. Gardner stated that she stayed in the vicinity "for the safety and security of the paramedic". She can be seen taking the prisoner into a nearby holding room while the paramedic makes a phone call. Ms. Gardner then returns to her desk and she testified that she did further paperwork. At 12:57 Ms. Gardner escorts the prisoner to a cell, noting that en route that she took a "quick look at 5". Next, the phone is ringing and Ms. Gardner said this would pertain to "another prisoner coming in".

[136] At 12:57 on the video the new prisoner is observed entering and Ms. Gardner explained how she processed him. She noted that at 1:01 Mr. Fraser came back from lunch and she noted (he can be seen doing this on the video) that he "looked in 5". By 1:03 she finished the new prisoner's paperwork and Mr. Fraser can be observed near her at his desk in the booking area. Ms. Gardner went on her lunch break at 1:20, leaving Mr. Fraser as the sole booking officer on duty, until her return at 2:17.

**THE EXPERT EVIDENCE**

[137] The Crown called Dr. Marnie Wood and Ms. Gardner called Dr. David Chiasson and Dr. Robert Langille. Drs. Wood and Chiasson were qualified as forensic pathologists, able to give opinion evidence as to the cause and manner of death. Dr. Robert Langille, a Ph.D. and not a medical doctor, was qualified as a toxicologist, able to give opinion evidence as to what level of alcohol poisoning can cause death.

## Dr. Marnie Wood

[138] Dr. Wood's Report of Post Mortem Examination (Autopsy Report) completed October 13, 2016 was introduced as exhibit 11 and she also touched upon her Report of Medical Examiner (M.E. Report) of the same date (contained within exhibit 14).

[139] The Autopsy Report is based on Dr. Wood's June 16, 2016 autopsy and the relevant background material. After listing these materials, Dr. Wood noted:

> This 41 year old man had a medical history of depression and ethanol abuse. Records report that, at times, he consumed up to 40 ounces of alcohol in a day. He was placed in a jail cell on June 15, 2016 and found deceased early morning June 16, 2016. Evidence suggests he drank a bottle of whiskey immediately prior to his arrest by police.

[140] Dr. Wood reviewed the same video that was played in Court depicting Mr. Rogers' last hours while situated in the dry cell. Having regard to my review of the video contained within exhibit 10, I find Dr. Wood's "bullet point" Autopsy Report summary to be an accurate depiction of what the video shows and that the times are largely accurate:

- Mr. Rogers being carried, handcuffed, into booking area and laid on floor prone (face down) with a spit hood (fluid resistant hood over head and face, designed to prevent transmission of body fluids) in place, at approximately 23:06 June 15, 2016.
- At approximately 23:08 he is carried into a cell, placed prone, with spit hood in situ. Handcuffs are removed. He moves his arms and hands slightly. His elbows are bent with hands above his head and left knee bent slightly, chest toward floor. Spit hood remains in place, over face.
- At approximately 23:11 he rolls his lower body slightly to the right so left arm under body and right knee bent up toward abdomen. Chest toward floor. Spit hood remains in place, over face.
- At approximately 23:12 through 23:14 he moves onto his hands and knees and shifts lower body to a right lateral position, with knees bent up toward abdomen, left arm over head, right elbow bent so that right hand at head level, check toward floor. Spit hood remains in place.
- There is little appreciable movement by Rogers until approximately 23:31, when there is slight movement of head and body.
- At approximately 23:33 his abdomen contracts and chest lifts off the floor. This "heaving" motion is suggestive of vomiting. This motion, as well as slight lifting and settling of head and chest, occurs several times between 23:33 and 23:41. Spit hood remains in place over face.
- There is no appreciable movement of his body between 23:41 and 01:39. Any movement of breathing it is not apparent on the video.
- At approximately 01:39 a police officer enters the cell, attempts to rouse Rogers, and removes the spit hood. The body is not repositioned.
- At approximately 01:49 EHS members enter the cell, place leads on Rogers and hook to a monitor. The body is not repositioned..
- EHS staff departs the cell at approximately 01:56 (EHS written record notes death was declared at 01:53) and return at 01:59 to place a sheet over the body.

[141] I note that she described the video as "grainy" (and I agree with this description) such that subtle movements (if made) of Mr. Rogers cannot be observed. With reference to the above quoted bullet point timeline, Dr. Wood said, and I agree, that there is no "apparent movement" of Mr. Rogers after 23:41.

[142] Although she could not discern Mr. Rogers's body moving after 23:41, Dr. Wood said that it is possible that there could have been subtle movement (not possible to see from the poor quality video). She added that for the majority of time before 11:41 she could not observe Mr. Rogers breathing on the video. Asked for an exact time when Mr. Rogers died, she stated that she could not narrow down the time any further. Dr. Wood agreed that if she could have observed/heard Mr. Rogers breathing on the video that it would have been easier to rule his time of death.

[143] On cross-examination Dr. Wood admitted that whereas the grainy video prevented her from observing breathing, the people who looked into the cell could have seen and heard breathing.

[144] Dr. Wood was asked to review the sixth bullet point. She stated, "you can't really see if he's vomiting here – at some point he did – this could have been a dry heave". Later she agreed that "we don't' know the specific time when he vomited … it's entirely possible he continued breathing past 11:41".

[145] On cross-examination she agreed that the timing of the vomiting and airway obstruction would be different but "closely occurring".

[146] The M.E. Report records Mr. Rogers' blood alcohol concentration (BAC) at 0.367 g/100 ml. Dr. Wood testified that she considered this in forming her opinion as follows at p. 3 of her Autopsy Report:

> The concentration of ethanol detected was lower than the reported fatal range, and is even less likely to have been fatal in a person with a history of chronic ethanol abuse. Thus, the cause of death is not ethanol intoxication.

[147] Dr. Wood elaborated that it is possible, but not common for a person to die from alcohol ingestion when their BAC is around .4. She said that the estimated fatal range is more likely .5 to .6, "in my experience, .5 and greater". According to Dr. Wood, .367 could be a cause of death but that it is not definitive because such a reading is "survivable in some cases".

[148] On cross-examination Dr. Wood agreed that she did not classify the .367 reading as fatal for Mr. Rogers. She based this opinion from her review of the texts. Dr. Wood acknowledged that the referenced articles in the texts stated that a .367 reading could be potentially lethal.

[149] Dr. Wood said that she reviewed Dr. Langille's report and the referenced papers adding that she considered the .367 in the context of this particular case. She stated that she considers the individual's level or tolerance for alcohol.

[150] Asked if the .367 reading could have been fatal for Mr. Rogers she acknowledged that, "it could be the alcohol". She then spoke of her formulation drawing upon an analogy of a person with a seizure disorder taking a seizure in a pool. Since the person would drown on account of being in the pool, she would note drowning as the cause of death. She added that was how she thought about Mr. Rogers' cause of death, that the level of alcohol prevented him from removing the spit hood. She said that the spit hood was "occlusive enough … it prevented oxygen from getting to him". She elaborated that it was the vomit in the spit hood – "how blocking it was" – wondering whether it was "total or partial". Dr. Wood then gave her opinion, "that the blocking of that material, fluid soaked, would have caused smothering …".

[151] Dr. Wood examined the spit hood, noting that it was stained with vomit. With the aid of the photographs (exhibit 1), she focused on eight and nine showing "pooled liquid" on the spit hood.

[152] With respect to Mr. Rogers' alcohol use, Dr. Wood noted that a December 5, 2015 health assessment revealed that he was drinking up to 40 ounces of alcohol per day. She concluded that he was a "heavy drinker" and an abuser of alcohol with his organs being susceptible to alcohol abuse.

[153] Dr. Wood stated that Mr. Rogers had a history of chronic alcohol abuse. She was mindful of the December 5, 2015 health assessment where it was reported that Mr. Rogers "at least at that time" was consuming 40 ounces of alcohol per day. She felt Mr. Rogers to be a "binge drinker". Dr. Wood stated that there was no available information about Mr. Rogers' pattern of drinking between December 5, 2015 and June 16, 2016; "… his tolerance may have changed, we just don't know".

[154] Dr. Wood confirmed her opinion that Mr. Rogers's cause of death was by suffocation or asphyxiation, "the failure of cells to get or use oxygen". She said Mr. Rogers' nose and mouth were obstructed adding that it generally takes three to ten minutes for a person to suffocate. Dr. Wood stated that Mr. Rogers' airway was obstructed by vomit in the spit hood. Dr. Wood allowed that the cessation of one's pulse could take longer than three to ten minutes.

[155] Dr. Wood stated that irreparable brain damage would have occurred "within three to ten minutes, or maybe a little longer". She added that case reports show that vital bodily functions can keep going for up to 20 minutes after irreparable brain damage. With this in mind, Dr. Wood acknowledged that "subtle movements" may be observable in a person for 20 to 30 minutes before death. Considering the 23:41 time, Dr. Wood agreed that Mr. Rogers irreparable brain damage would have been (on the outside) of 23:51 and by 12:11 he would be dead.

[156] Dr. Wood distinguished between the "cause" and "manner" of death. She classified the cause of death as "asphyxia due to suffocation" and the manner of death as "accident". Based on her autopsy Dr. Wood ruled Mr. Rogers' death an accident because there was no intent; i.e., self harm or harm by another person. Accordingly, she ruled out suicide or homicide.

[157] Dr. Wood acknowledged that she cannot observe a living person and determine their blood/alcohol content. She agreed that she did not have this kind of training; "its outside my level of experience".

[158] On cross-examination Dr. Wood admitted that she did not consult with a toxicologist before preparing her reports / arriving at her opinions. She was taken to p. 5 of Dr. Chiasson's report:

> … The absence of any vomit within the mouth or major airways at the time of autopsy does suggest to me that the decedent was already very deeply unconscious when the vomiting occurred. It is therefore plausible that the decedent was already close to death when vomiting occurred and that the presence of the hood played a very limited role in this death.

[159] Dr. Wood agreed that the photographs do not reveal the volume of vomit in Mr. Rogers' mouth. She said that his mouth, nose and the side of his head were vomit stained. She acknowledged that removing the spit hood could have caused the vomit to move up the side of Mr. Rogers' head.

[160] After Mr. Rogers vomited Dr. Wood expects that it would have pooled, "with gravity, where his nose and mouth were pressed". Although she cannot observe from the photographs, Dr. Wood "expects the occlusion was due to submersion of the nose and mouth in vomit". She agreed that there are no photographs from inside the spit hood.

[161] Dr. Wood believes that after initially vomiting Mr. Rogers would have kept breathing for some time. Ultimately, Mr. Rogers would have aspirated. Dr. Wood

did not find vomit staining in Mr. Rogers' mouth or air passages On this point she stated, "he did not breathe in for a sufficient degree [for the vomit] to go in the airway … I suspect he tried to breath after he vomited".

**Dr. Robert Langille**

[162] Dr. Langille worked as a forensic toxicologist with the Centre of Forensic Sciences in Toronto between 1997 and 2017. His training and experience centers around the absorption, distribution, elimination and behavioral affects of alcohol and drugs in the human body. He has authored numerous articles and taught courses in this area.

[163] Neither a medical doctor or pharmacist, most of Dr. Langille's work has been in cases involving impaired driving. He has never provided an opinion with respect to the cause and manner of death. On cross-examination he agreed that given his expertise, he can only state within a certain range if alcohol poisoning can cause a person's death. He further agreed that the range is very broad.

[164] Dr. Langille said that a deceased's alcohol level is most reliably determined from obtaining it from blood or urine and not from the vitreous (eye) fluid. He stated that determining alcohol content from urine is, "a much better predictor of where one is on the BAC curve".

[165] Dr. Langille highlighted his October 5, 2021 report (Toxicology Report). He confirmed that in preparation for writing the Toxicology Report that he reviewed Dr. Wood's Report, the sentencing decision (post the jury trial) and NMS labs report.

[166] On cross-examination he acknowledged that he did not review the trial transcript, witness statements or any of the videos. Although he was aware that Mr. Rogers had "downed, all at once" half a pint of Fireball Cinnamon Whiskey, he did not use this information in forming his opinion. He agreed this event would classify as "bolus", the ingestion of a large amount of alcohol at one time. He agreed that one of the risks of a bolus event is that the person may vomit. He added that those less experienced with alcohol "tend to vomit more".

[167] Dr. Langille was taken to Dr. Wood's Report and her penultimate opinion at p. 3:

> The concentration of ethanol detected was lower than the reported fatal range, and is even less likely to have been fatal in a person with a history of chronic ethanol abuse. Thus, the cause of death is not ethanol intoxication.

[168] He said that he disagreed, re-iterating his view that "Dr. Wood's opinion is contradicted by a significant body of scientific literature on the range of BACs determined in cases where individuals' death has been attributed to alcohol poisoning". Having said this, Dr. Langille agreed that it is by no means certain that a .367 BAC would cause death in Mr. Rogers.

[169] Dr. Langille noted that in his experience there are fatalities with BACs in the .350 range, adding, "alcoholics often classify as lower". He elaborated that he was aware of a case where there was a death from a .048 reading in an alcoholic. With a reading of .367 BAC, Dr. Langille confirmed that this is about four and one half times over the .080 legal driving limit.

[170] On cross-examination Dr. Langille said that he considered a 2003 study in the Journal of Forensic Science and that "opinions differ about the BAC [level] to cause death". He agreed that it is not always clear whether alcohol as a cause of death is a primary or contributing factor.

[171] Dr. Langille touched on "chronic tolerance" of alcohol in some individuals. He agreed that some individuals with readings of up to .400 BAC have attempted to drive vehicles. He noted that the literature referenced a range of .168 - .600 BAC as the range in 94 fatalities attributable to deaths of alcoholics, agreeing that this is a "broad range".

[172] Dr. Langille stated that Dr. Wood relied on "a summary text [book] … it's a beginning point". He said that his opinion is based on more current, specialized articles.

[173] Dr. Langille was asked about the available information pertaining to Mr. Rogers' medical history. He noted that the health assessment precedes Mr. Rogers' death by about six months and that, "his pattern of drinking may have changed… we don't know about his daily drinking habits". Dr. Langille added that one cannot be sure about Mr. Rogers' "specific level of tolerance", regarding alcohol in mid June, 2015. Having said this, he stated that Mr. Rogers was picked up because of intoxication, "so he was well beyond his level of tolerance".

[174] Dr. Langille explained that one's alcohol tolerance is built up over time and with respect to Mr. Rogers, referred to this passage in the Toxicology Report:

> Tolerance to a specific level of alcohol can change significantly over a period of one month and there is no way to determine what BACs Mr. Rogers was tolerant to from the data summarized in Dr. Wood's report. Thus, in my opinion this information can not negate the demonstrably fatal potential of Mr. Rogers' BAC as described in the scientific studies cited above.

[175] Dr. Langille noted that most alcohol abuse treatment programs involve abstinence for two to four week periods and that "individuals lose tolerance of alcohol over a period of abstinence over several weeks… on the flip side, people who consume more alcohol over many drinking sessions develop tolerance".

[176] Dr. Langille agreed that for a 5′, 5″ tall, 150 pound person (i.e., Corey Rogers), to get to a .200 BAC would require the ingestion of 19 – 25 1-ounce drinks of 40 percent alcohol spirits. The bolus event involving the 33 percent Fireball Cinnamon Whisky would raise the individual's BAC by 84 mg. over 100 ml. Dr. Langille agreed that after consuming that amount of whisky in a bolus event that it would take 2 – 4 hours to eliminate it.

[177] Dr. Langille agreed that there is a "range of alcohol absorption" and that over time alcohol is also eliminated from one's system. Further, once dead, individuals do not eliminate alcohol. Returning to Mr. Rogers' .367 BAC, Dr. Langille stated that if the Fireball Cinnamon Whisky consumption equated with .84 BAC (taking into account absorption and elimination), 18 – 21 more drinks would be required for him to reach .367 BAC.

[178] Dr. Langille was reminded that Mr. Rogers was refused entry to the liquor store and IWK on account of his level of intoxication. Although impaired by alcohol, Dr. Langille noted that there are individuals who can drink high levels of alcohol and "walk and talk".

[179] On cross-examination Dr. Langille was asked about how he trained police officers in observing alcohol indicia. He agreed that he taught police to "look out for sudden changes in impairment". He also taught that sudden changes may require obtaining medical assistance, especially if they become unresponsive or unarousable. On re-direct examination Dr. Langille said he did not know about the level of training police and/or booking officers received in Nova Scotia.

**Dr. David A. Chiasson**

[180] Dr. Chiasson identified his December 31, 2021 report (Dr. Chiasson's Report) entered as exhibit 14, tab 1. He confirmed that he reviewed these materials in advance of writing his report:

1. Dr. Marnie Wood's Report of Postmortem Examination (Reference 16-ME-75727) and NMS laboratory toxicology report relating to the decedent Corey James ROGERS
2. IWK, police station (booking area and cells)
3. "Timeline" documents x 5 (4 pdf; 1 Word doc)
4. A PDF file labelled '2016-016 HRP Rogers, Corey' (Crown disclosure file including photos taken by the investigators and the medical examiner.)
5. Transcript of all the evidence taken at trial in this matter
6. An excel spreadsheet called 'Key – Photos and Transcripts'

[181] He noted that conjunctivae (hemorrhages seen in the lining of the eye) is often but not always present when a person dies of asphyxiation. Dr. Chiasson then reviewed his opinion (page 5, para. 2 of Dr. Chiasson's Report):

> Asphyxia occurs when the process by which the tissues of the body receive oxygen is compromised. It is a mechanism of death, which can occur from a wide variety of underlying causes, both natural and non-natural. Suffocation may be variably defined, but in the context of this death, it would appear to indicate that asphyxia is the result of obstruction of the external air passages (mouth and nose), also know as "smothering". Since the physical findings at autopsy in smothering-related deaths are often minimal (or in some instances completely absent), the diagnosis is commonly based primarily on circumstantial / scene evidence, particularly when no alternative cause of death is apparent.

[182] He added that there can be many forms of death by asphyxia including suffocation. Dr. Chiasson stated that "suffocation is arguably a generic term".

[183] Dr. Chiasson next went over his opinion at p. 5, para 3:

> Based on my review of the circumstances of death, the autopsy findings, the NMS Labs toxicology report, and the interpretation of the toxicology findings provided by Dr. Langille, it is my opinion that the proximate (underlying) cause of Mr. Rogers' death was acute ethanol intoxication.

[184] He stressed the importance of examining the circumstantial evidence, adding that many causes of death are based on a "diagnoses of exclusion". With reference

to p. 3 of the Dr. Chiasson Report he noted that with Mr. Rogers there was vomit on his face but not in his mouth.

[185] Dr. Chiasson said that vomiting is a common finding in many deaths. He elaborated that when a person dies "it is common for their esophagus to lose contractability…food comes up and is aspirated back down… in a person who vomits there are obstructed airwaves, if there's any level of consciousness, they'd breath in or aspirate into at least their mouth and upper airwaves". He noted that based on his review there was no vomit in the mouth or airways with Mr. Rogers. In the result, Dr. Chiasson believes that Mr. Rogers, "must have been very deeply unconscious, comatose at the time, because if not, a person would react to get out of the circumstances". Dr. Chiasson said that even in situations where a person is not deeply unconscious their reaction would be to, 'breath the vomit in, at least to the mouth if not further down".

[186] Dr. Chiasson provided his opinion as set out at p. 5 (last para) of the Dr. Chiasson Report:

> In conclusion, it is my opinion to a high degree of medical certainty that the proximate (underlying) cause of Mr. Rogers' death was acute ethanol intoxication is considered to be sufficient, in and of itself, to account for the death. Had the decedent not been severely intoxicated, he would not have been expected to die in the circumstances that he did. Whether or not he would have died had the spit hood not been placed about his head cannot be determined based on forensic pathological analysis.

[187] He added that "he [Mr. Rogers] has a level of alcohol – Dr. Langille confirmed my belief – that .367 is sufficient to be a cause of death in and of itself, certainly potentially fatal.".

[188] Asked about the role of the spit hood, he replied, we can't determine on a forensic pathology analysis… a potential contributing factor.". Dr. Chiasson added, "we don't have signs of asphyxia, conjunctivitis".

[189] Dr. Chiasson elaborated that upon reviewing the video he noted the part where Mr. Rogers was heaving (from the movement of his abdomen) and that this could be vomiting. He continued, "he's in agonal phase, dying then".

[190] Dr. Chiasson confirmed that he examined the spit hood and photographs. He stated that vomit could be observed in the spit hood. He said that he could not say how much Mr. Rogers' airways were obstructed and that even if his nose was

completely occluded, a person can breath through their mouth (and *vice versa*). Dr. Chiasson concluded, "there is not pathology that tells us he occluded." He said that had Mr. Rogers' BAC been lower then "there is an argument the hood… is much more likely a contributing factor, but here his BAC is high and I come back to the point there's good evidence he has very low level of consciousness when he vomits because he's not trying to breath in".

[191] Dr. Chiasson spoke of the "dying process" noting that the duration is uncertain given so many variables. In Mr. Rogers' case he said that one cannot state the exact time of death.

[192] On cross-examination Dr. Chiasson said he took issue with Dr. Wood's opinion because she does not include "alcohol intoxication in her cause of death at all". He agreed that asphyxia due to smothering "is certainly a possibility but not simply that". Although it is not in her report, Dr. Chiasson (who sat in on Dr. Wood's testimony) agreed that she factored alcohol into her opinion when testifying. He agreed that because of Mr. Rogers' vulnerable state he was unable to remove the spit hood. He allowed that it is possible that Mr. Rogers tried to breath in and vomit entered. He agreed that it is possible that if an individual was face down that gravity could result in vomit coming back out. He added, however that if a person breathes in vomit that he would not expect it to flow out, "it goes to the back of the throat and down".

[193] Dr. Chiasson acknowledged that if a very unconscious person was face down in liquid that this could be a contributing factor in the cause of death. He further agreed that leaving the spit hood on could have been a contributing factor in Mr. Rogers' death. Dr. Chiasson admitted that leaving a "severely unconscious, heavily intoxicated person alone with a spit hood on was a dangerous thing to do".

[194] On cross-examination Dr. Chiasson agreed that alcohol poisoning in and of itself is not fatal in all cases because medical treatment can be administered. He added that some individuals can "sleep it off and survive".

[195] On cross-examination he said that his conclusion relies in part on Dr. Langille's report, which states:

> Consequently, in the absence of other information, it is my scientific opinion that Mr. Roger's BAC of 367 milligrams of alcohol in 100 millilitres of blood falls within the range that is sufficient, on its own, to cause death due to alcohol poisoning.

[196] He later added that his opinion would have been the same without Dr. Langille's report. He stated that toxicologists often provide interpretive reports to assist pathologists.

[197] Dr. Chiasson agreed that there is a wide range – .168 to .600 – of potential BAC causing death. He agreed that there were cases of individuals operating motor vehicles with a BAC of higher than .367.

[198] On cross-examination he agreed that there are cases where there is death by asphyxiation with no signs of hemorrhaging. With Mr. Rogers he said that there is no physical evidence that he died of asphyxia. Nevertheless, he agreed that he could not rule out asphyxia as a cause of death.

[199] On cross-examination he reviewed photographs 62, 63 and 64 agreeing that there were vomit stains. He noted that the photographs are of good quality. Dr. Chiasson added, "there's nothing excessive or extensive there. We know vomit came out of his mouth and it looks like some went down the side of the face at the time of vomiting … I can't say much more than it's on the face, I'm not certain how it got there".

[200] Dr. Chiasson acknowledged that given the amount of liquid found in the spit hood, it could have been a factor in his death. He stated that he could not say what Mr. Rogers' outcome would have been had he not had the spit hood on, agreeing that he might have survived. Dr. Chiasson said that he was not sure if the spit hood had a role, that it could be a "complication of Mr. Rogers' acute intoxication … a potential contributing factor". He continued that without a spit hood Mr. Rogers could have succumbed to alcohol intoxication, alone. In retrospect, Dr. Chiasson agreed that leaving Mr. Rogers in the manner that he was left posed a significant threat to his life.

## THE ALLEGATIONS

[201] It is alleged that Cheryl Gardner and Dan Fraser each committed the offence of criminal negligence causing death by failing to:

(a) have Mr. Rogers medically assessed before accepting him into cells;

(b) adequately check on Mr. Rogers; and

(c) remove the spit hood from Mr. Rogers

**POSITIONS OF THE PARTIES**

## Crown

[202] The Crown submits that both booking officers are guilty as charged. It is submitted that neither Ms. Gardner or Mr. Fraser made their own judgments of Mr. Rogers because they effectively ignored him. The Crown refers to the evidence Sgt. Willett and Sgt. Gillett regarding cell checks and how they are easy to carry out and log. Having regard to their evidence the Crown submits that proper cell checks are much more thorough than what took place here.

[203] With respect to causation the Crown argues that Dr. Wood's evidence should be accepted by the Court. The Crown submits that her opinion is well supported on the evidence; that the cause of death was asphyxiation due to the blockage of Mr. Rogers' airwaves and not alcohol poisoning. The Crown points out that due to his lowered state of consciousness, Mr. Rogers could not extract himself from the spit hood such that it represented a fatal environment. In all of the circumstances the Crown submits that it is clear that Mr. Rogers died due to the occlusion. As for the defence experts, the Crown points out that Dr. Langille ignored the bolus event of Mr. Rogers downing the half pint of Fireball whiskey. Dr. Chiasson "relies heavily" on Dr. Langille's opinion to the detriment of his opinion. Further, the Crown submits that Dr. Chiasson ultimately acknowledges that the spit hood contributed to Mr. Rogers' death.

[204] The Crown asks the Court to weigh in on what they argue is Ms. Gardner's lack of credibility. Specifically, they point to her attempts to deny that Mr. Rogers was "a very drunk person who had thrown up with a spit hood on". The Crown says that her denials of hearing that Mr. Rogers chugged a half a point of whiskey are unbelievable, "selective memory at best," in the face of the video evidence. The Crown also submits that scrutiny of the video demonstrates that Ms. Gardner did not call Mr. Rogers' name to answer the medical questionnaire as she asserted. Further, they say that her evidence about spit hoods having been left on prisoners for up to two hours is new as she never previously testified to this.

[205] With respect to training the Crown argues that Ms. Gardner knew exactly what the 4 Rs were and how to properly carry out timely cell checks. This was especially the case on the night in question as it was not overly busy in the Crown's submission.

[206] The Crown submits that the policy heightens the level of care that should have been provided. Keeping in mind both policy and common sense, the Crown argues that leaving Mr. Rogers in a spit hood "just laying there" is criminal negligence.

[207] The Crown asks the Court to focus on the video of Mr. Rogers between 11:37 and 11:41 p.m. on June 15, 2016. It is pointed out that Ms. Gardner's cell check occurs at 11:37 when it is obvious from the video that Mr. Rogers begins heaving, and "after the first heave she walks away". The Crown reminds the Court that in her testimony Ms. Gardner simply recalled a shoulder shrug. They go on to submit that had proper checks been carried out that Mr. Rogers might not have died.

[208] With respect to Mr. Fraser, the Crown submits that his first cell check amounted to a "fly by". They argue that there is no evidence that he performed any assessment at Mr. Rogers' cell. The Crown asks the Court to review exhibit 8 and the video evidence which confirm that Mr. Fraser's cell checks at 12:55, 1:11 and 1:25 are "a falsification of the record" because they in fact did not occur. The Crown submits that this amounts to "a continuum of a pattern of conduct that is a substantial and marked departure from a reasonable booking officer".

[209] The Crown refers to exhibit 13, the transcribed notes from the video (after Mr. Rogers was found dead in cell 5) when the paramedic asks Mr. Fraser, "what time was he [Mr. Rogers] last seen?" and the reply:

> "It was about 15 – 20 minutes ago, my partner just when [sic] to lunch and she when [sic] by that way, did check him when she went by, I was doing up some paperwork and I went to a check now about quarter two, about 5 minutes ago, I cam back and I noticed, looked like he had crapped his pants. So I yelled to him are you Okay? Give me an answer, tried again and went in and realized the spit hood was on and took it off and stuff coming out of his mouth. Checked for a pulse and could not get one and he was not warm anymore, so…

[210] The Crown points out that Mr. Fraser had not checked on Mr. Rogers and, "he lied to EHS, the reason he lied is because he knows how important the cell checks are".

[211] In all of the circumstances the Crown says that upon accepting Mr. Rogers and by failing to do a proper assessment that the two booking officers showed a wanton and reckless disregard for Mr. Rogers. Even if the officers believed the comments that Mr. Rogers was "playing possum", they were not entitled to rely on that information and had to properly check on Mr. Rogers every 15 minutes. In the result, the Crown says this case is "very much like" the situation in *R. v. Doering*,

2019 ONSC 6360 where Justice Pomerance found Cst. Doering guilty of criminal negligence causing the death of a woman who was in his custody, as he "failed to provide Ms. Chrisjohn with the necessities of life and demonstrated a marked departure from the standard of care of a reasonably prudent police officer".

**Defence**

[212] The Defence asks the Court to consider what the true situation is in the PCF and not what the policy says. They point to Sgt. Gillett's evidence in this regard and his comment that the accused were "set up for failure".

[213] With respect to admitting Mr. Rogers, Ms. Gardner says that she properly relied on the police officers' observations. As for cell checks, the Defendants emphasize the reality of the situation in the PCF which often times houses unruly, dangerous prisoners. Again, they ask the Court to consider Sgt. Gillett's testimony and his acknowledgement that 4 R checks could be carried out without entering the cell. They point out that a true rousability check requires two booking officers, with one entering the cell. They point out that this was not the reality in the PCF and that booking officers' complainants about being short staffed fell on deaf ears. The Defence asks that Court to focus on the reality in the PCF and asks the rhetorical question, "[I]f what they were doing was so wrong, then why didn't anyone say so?" Ms. Gardner and Mr. Fraser point to the fact that the PCF was under constant video surveillance such that it was no secret as to how they carried out cell checks. They were never reprimanded and Sgt. Gillett expressed the view that both were caring booking officers.

[214] The Defence characterizes the order or policy as a "management driven" document. They submit that it has to be reasonable to be effective. Ms. Gardner and Mr. Fraser refer to *Doering* and the reference at para. 105 that policies do not have the force of law.

[215] With respect to the expert evidence, the Defence submits that Dr. Langille taught Ontario police officers how to watch for signs of intoxication but that there is no evidence that HPD police or booking officers had this type of training.

[216] When it comes to the spit hood the Defence points out that the booking officers had no training. They acknowledge that Mr. Rogers' face could not be seen through the cloth item; however, they emphasize that the spit hood was put on out of necessity. As to why it was not removed, the Defence argues that Mr. Rogers

remained a risk, especially because once he was placed in the cells his handcuffs were removed.

[217] The Defence submits this is not a case where there was a refusal to provide care. They add that it is also not a situation where a prisoner's requests were ignored. As for Ms. Gardner's sarcastic comment about Mr. Rogers being "father of the year", Ms. Gardner characterizes this as off handed and that one cannot conclude that it coloured her judgment because she did check on Mr. Rogers.

[218] In the main the Defence submits that Mr. Rogers' consumption of alcohol put into motion a chain of events. With respect to causation, they submit that it must be determined on the facts and that the Crown bears the burden. They argue that when one considers the expert evidence that it cannot be said that any omissions of the Defendants caused the death of Mr. Rogers. In this regard they point to the mechanism of death. Ms. Gardner and Mr. Fraser submit that Dr. Wood's opinion is flawed because she underplays the significance of the .367 BAC in Mr. Rogers. They point out that Dr. Wood relied on Mr. Rogers' six months dated information in determining Mr. Rogers' pattern of drinking. In all of the circumstances the Defence submits that Dr. Chiasson's opinion should be preferred as he acknowledges the realistic possibility that alcohol intoxication could solely have caused Mr. Rogers to die. As for the role of the spit hood, it is submitted that given their testimony that neither of the pathologists can state with certainty what, if any, role it played in the death of Mr. Rogers. With this in mind they submit that there is no evidence as to what could have been done to save his life.

[219] In the main the Defence argues that the booking officers did not show wanton or reckless disregard for Mr. Rogers. They submit that the booking officers were simply doing their job according to the then expectations. The Defendants ask the Court to consider all of the evidence in the context of the PCF which deals with a vulnerable and difficult population. They emphasize their position "at the bottom of the food chain" and that pleas for support were largely ignored.

[220] Mr. Fraser acknowledges that there are three entries with no corresponding checks. He submits that while obviously "problematic" that they are not critical when one considers the facts and the causation component.

## LEGAL FRAMEWORK

[221] As mentioned at the outset of this decision, in *R. v. Gardner*, 2021 NSCA 52 our Court of Appeal provides a helpful roadmap for analyzing this case. As with the

first trial, no one disputes that the two accused booking officers owed a duty of care to Mr. Rogers. What I am left to decide is whether the Crown has established beyond a reasonable doubt whether the acts or omissions of Ms. Gardner and/or Mr. Fraser showed a wanton or reckless disregard for the life or safety of Mr. Rogers. If the acts or omissions of one or both of the booking officers caused Mr. Rogers' death, I must determine if they were a marked departure from the standard of care of a reasonable and prudent booking officer in their circumstances. Finally, I must decide whether the acts or admissions of the accused persons amounted to a significant contributing cause to Mr. Rogers' death.

## Criminal Negligence Causing Death – the *Criminal Code*

[222] Sections 219 (1), 219 (2) and 220 read as follows:

> 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.
>
> 219(2) For the purposes of this section, "duty" means a duty imposed by law
>
> 220 Every person who by criminal negligence causes death to another person is guilty of an indictable office …

## Wanton or Reckless Disregard

[223] In *Gardner*, Justice Beveridge explained what is meant by "wanton or reckless disregard" with reference to authorities from the Ontario Court of Appeal and Supreme Court of Canada:

> [65] Various terms have been used to describe what is meant by "wanton or reckless disregard". Cory J.A., in *R. v. Waite, supra,* whose decision was adopted as a correct statement of the law by three members of the Supreme Court, described the term:
>
> > [62] ... The word "wanton" means "heedlessly". "Wanton" coupled as it is with the word "reckless", must mean heedless of the consequences or without regard for the consequences. If this is correct, then it is immaterial whether an accused subjectively considered the risks involved in his conduct as the section itself may render culpable an act done which shows a wanton or reckless disregard of consequences. ...

> [66] The Ontario Court of Appeal in *R. v. L.(J.)* (2006), 204 C.C.C. (3d) 324 referred, with approval, to the comments of Hill J. in *R. v. Menezes*, [2002] O.J. No. 551 (QL), where he wrote:
>
> > [72] Criminal negligence amounts to a wanton and reckless disregard for the lives and safety of others: *Criminal Code*, s. 219(1). This is a higher degree of moral blameworthiness than dangerous driving: *Anderson v. The Queen* (1990), 53 C.C.C. (3d) 481 (S.C.C.) at 486 per Sopinka J.; *Regina v. Fortier* (1998), 127 C.C.C. (3d) 217 (Que. C.A.) at 223 per LeBel J.A. (as he then was). This is a marked and substantial departure in all of the circumstances from the standard of care of a reasonable person: *Waite v. The Queen* (1989), 48 C.C.C. (3d) 1 (S.C.C.) at 5 per McIntyre J.; *Regina v. Barron* (1985), 48 C.R. (3d) 334 (Ont. C.A.) at 340 per Goodman J.A. **The term wanton means "heedlessly" (*Regina v. Waite* (1996), 28 C.C.C. (3d) 326 (Ont. C.A.) at 341 per Cory J.A. (as he then was)) or "ungoverned" and "undisciplined" (as approved in *Regina v. Sharp* (1984), 12 C.C.C. (3d) 428 (Ont. C.A.) at 430 per Morden J.A.)) or an "unrestrained disregard for consequences" (*Regina v. Pinske* (1988), 6 M.V.R. (2d) 19 (B.C.C.A.) at 33 per Craig J.A. (affirmed on a different basis [1989] 2 S.C.R. 979 at 979 per Lamer J. (as he then was)). The word "reckless" means "heedless of consequences, headlong, irresponsible": *Regina v. Sharp, supra* at 30.**
> >
> > [Emphasis added by Justice Beveridge]

**Standard of Care**

[224] Beveridge, JA comprehensively reviewed standard of care at paras. 67 – 76 of *Gardner*. As he stated at the outset of his review:

> [67] For any trier of fact to wrestle with the issue of whether the acts or omissions of an accused amounted to a marked and substantial departure from the requisite standard of care requires awareness of what that standard is and how it is established.

[225] As with the initial trial, the Crown did not tender expert evidence about the standard of care of a reasonable and prudent booking officer. In the result, I am left to draw inferences from the evidence about what the standard of care was and hence whether the two accused's acts or omissions amounted to a marked and substantial departure from it.

**Marked and Substantial Departure**

[226] In *Gardner*, Justice Beveridge distinguished criminal negligence from civil negligence by requiring moral blameworthy behaviour, reasoning:

> [77] Criminal negligence is nonetheless negligence--a breach of the appropriate standard of care. Constitutional norms dictate criminal negligence be differentiated from civil negligence by requiring morally blameworthy behaviour--that is, behaviour that was a marked and substantial departure from the standard of care a reasonable person would have observed in all of the circumstances.
>
> [78] The second thing that distinguishes penal from civil negligence is for the latter, liability is determined on a purely objective basis. The former operates under a modified objective test.
>
> [79] The modified objective test requires the court to be alive to the possibility that the accused's honestly held and reasonable perception of the circumstances are such that a reasonable person might not have appreciated the risk or could and would have done something to avoid the danger (see: *Beatty*, *supra*, at paras. 37-38; *R. v. Tutton*, *supra*, at para. 45).
>
> [80] That is, the state of mind of the accused is not, as in civil cases, irrelevant. It can lead to acquittal if it creates a doubt that a reasonably prudent person would have appreciated the risks with the act or failure to act (see, for example: *R. v. Beatty, supra* at para. 43; *R. v. Doering, supra* at para. 93; *R. v. Ibrahim*, 2019 ONCA 631 at paras. 33-34).

## Causation

[227] Finally, and picking up on Justice Beveridge's guidance at para. 81 of *Gardner*, I must also determine if the acts or omissions of the accused amounted to a significant contributing cause of the victim's death.

### ANALYSIS AND DISPOSITION

[228] Given all of the evidence the question must be determined as to whether the Crown has proved beyond a reasonable doubt that the acts or omissions of Ms. Gardner and/or Mr. Fraser showed a wanton or reckless disregard for the life or safety of Mr. Rogers and that their behaviour amounted to a marked and substantial departure from the standard of care. I must then go on to consider causation.

## Credibility of Cheryl Gardner

[229] The Crown challenges Ms. Gardner's credibility on several fronts and I agree with a number of their submissions. For example, despite her denials, the Crown says that Cst. Morris said in the presence of Ms. Gardner that Mr. Rogers consumed

half a pint of alcohol. His exact words are contained within tab 6 (p. 530) of exhibit 13:

> "I am impressed with how quick he got that half pint down …took off …in one second before I got out and around to the side of the car, he had killed it all".

[230] I also agree that exhibit 13 confirms that Ms. Gardner did not call Mr. Rogers' name to answer the medical questionnaire. Further, the Crown demonstrated through cross-examination that Ms. Gardner had never before testified that she knew spit hoods could be left on prisoners for up to two hours.

[231] Notwithstanding the above examples, overall I am of the view that Ms. Gardner was a believable witness. She was subjected to a withering cross-examination and acknowledged several polices that were not in line with her practices at the PCF.

[232] In the main I found Ms. Gardner to be credible and reliable as I reviewed her testimony in the context of the exhibits and other testimony. While it is true with the benefit of hindsight that we can all agree that Mr. Rogers was highly intoxicated, the fact that she did not agree with the characterization that he was "a very drunk person" does not equate with a lack of credibility. I say this with reference to what all three officers and Ms. Spindler said about Mr. Rogers' level of intoxication.

[233] The police officers made the decision to take Mr. Rogers to the PCF over the two other options of taking him home or to the hospital. They knew from Ms. Spindler that nobody was at home and therefore, that it would not be wise to leave the intoxicated Mr. Rogers there alone. Ms. Spindler suggested that the police take her boyfriend to the "drunk tank". She would have known Mr. Rogers' drinking habits and formed the view that although he was intoxicated, his alcohol level was not as high as what she had observed on other occasions.

[234] The booking officers on duty received word via radio that Mr. Rogers was en route. He had been arrested under the *LCA*, s., 87; a not uncommon circumstance for someone coming to the cells. Ms. Gardner held the door open for the officers who brought in the unruly Mr. Rogers. I say unruly because the video shows him upon arrival and it is obvious that he is uncooperative and not responding to officers' commands. By this point, Cst. Paris had placed a spit hood over Mr. Rogers' head. Whereas an intoxicated arrestee would be commonplace in the PCF, one with a spit hood on represented a relative rarity. Given the evidence, a prisoner with a spit hood on while not in a restraint chair would be especially rare.

[235] The booking officers accepted Mr. Rogers into the PCF and he then became their responsibility. As per protocol, Ms. Gardner relied on her own observations and those of the police officers when she decided to have Mr. Rogers placed in one of the dry cells. She testified that she thought him to be intoxicated, but not highly intoxicated. Having reviewed all of the evidence, I do not find this to be an unreasonable determination. The fact is that when he died Mr. Rogers was found to have a .367 BAC. We know from the expert evidence that this reading means that he was highly intoxicated. Although Ms. Gardner thought otherwise, I find that based on her level of training and what she learned from observing Mr. Rogers and listening to the police officers, that she was reasonably of the view that Mr. Rogers was merely intoxicated. Although Mr. Rogers was not walking on his own, the police officers told Ms. Gardner that he was purposely being uncooperative. Similarly, although he was not answering questions or responding to directions, I am of the view that it was reasonable for Ms. Gardner to have concluded that this was due to defiance rather than a highly intoxicated state. I say this bearing in mind the report that she received over the radio from Cst. Murphy coupled with what was going on with Mr. Rogers for all to observe in the booking area.

[236] As Sgt. Gillett testified, the dry cell was designated for prisoners who might harm themselves or others. Given Mr. Rogers' recent history (as reported after the encounter at the IWK and given his presentation at the PCF), I find that the choice of the dry cell was not unreasonable. Having said this, I wish to make it clear that with the benefit of hindsight it is obvious that Mr. Rogers should have been promptly taken to the hospital or attended to by EHS.

[237] With a BAC of .367 Mr. Rogers should never have been left alone in the dry cell, wearing a spit hood. Once again, however, it is important to remember that given his actions and behaviour the police and booking officers were of the erroneous but understandable view that Mr. Rogers was merely intoxicated and not highly intoxicated.

[238] While experienced in making observations about alcohol impairment indicia, the officers did not have training with regard to the effect of alcohol on the central nervous system. Further, there is no evidence that they underwent the kind of training in dealing with impaired people such as Ontario officers received as Dr. Langille testified to. In any event, from the uncontradicted evidence of Ms. Gardner it would appear that booking officers only received perfunctory alcohol indicia training.

[239] With respect to the spit hood, I find that there was a lack of training on proper spit hood use at the material time. When I recall the evidence of the three arresting officers and Ms. Gardner, it is clear that spit hood training was non-existent. Further, Sgt. Gillett confirmed that the police and booking officers did not receive training in spit hood safety. While it is true that spit hoods came with labels spelling out their proper use, on the evidence it is clear that this instruction was rather obscure (rolled up inside the spit hood packaging) and that officers only became aware of the importance of these instructions after Mr. Rogers' death.

[240] In deciding whether the acts or omissions of booking officers amounted to a substantial departure from the requisite standard of care, I must consider the evidence on the standard of care at the PCF in June, 2016. The Crown did not tender expert evidence but instead relied on the testimony of S/Sgt. Willett and Sgt. Gillett. When considering the standard of care, I am also cognizant of the evidence of Csts. Paris and Murphy as well at Ms. Gardner regarding their experience working at the PCF.

[241] With respect to cell checks, S/Sgt. Willett's practice was to open the cell and attempt to rouse an unresponsive prisoner. Sgt. Gillett also spoke of going inside the cell; however, he confirmed that a 4 R check can be done from outside the cell.

[242] I found Sgt. Gillett's evidence to be significantly more determinative of the requisite standard of care than S/Sgt. Willett's testimony because Sgt. Gillett was the NCO at the material time and S/Sgt. Willett's practice was restricted to his time as NCO between 2010 and 2012. Furthermore, S/Sgt. Willett spoke more in terms of his own practices as NCO, whereas Sgt. Gillett addressed the booking officers' practices.

[243] By June, 2016 Cst. Paris had worked a number of shifts in the PCF over the course of ten years. Prior to the events involving Mr. Rogers, she had no idea about the 4 Rs. She learned the routine for checking on prisoners in cells from other police or booking officers. She could not recall guidelines. She said a prisoner should be checked on every 15 minutes and that this check happened from outside of the cell. Citing safety concerns, Cst. Paris never went into a cell alone with a prisoner.

[244] Cst. Murphy mainly testified about the PCF in the context of the practices of booking officer, Stephan Longtin. Apparently, Mr. Longtin had a personal rule to always call in EHS when an intoxicated person arrived at the PCF. While laudable and critically here, something that might have saved Mr. Rogers, I do not find based on all of the evidence that Mr. Longtin's approach was the PCF standard as at 2016.

[245] Ms. Gardner spoke to her practices in the PCF and their relationship to the policy (exhibit 4). In short, she emphasized that in practice the policies were more of a guideline. In this regard she spoke of the practical realities in the PCF which she said were recognized by her supervisors and notably, Sgt. Gillett.

[246] Of all of the standard of care evidence I am most informed by Sgt. Gillett's testimony. At the relevant time he was in charge of auditing the PCF booking office. He expressed concerns about what transpired there, stating his view that Mr. Rogers should have been medically assessed. Nevertheless, when I drill down on Sgt. Gillett's evidence the realities of the PCF in 2016 become apparent, including:

- booking officers had a great deal of discretion as to whether they accept a prisoner into the PCF
- the prisoner medical information form is voluntary and booking officers were not required to obtain verbal answers from the prisoner
- booking officers' general duties are extensive such that they may be busy on any given shift, even without a high volume of prisoners
- 4 R checks do not require that the officer enters the cell
- in the time leading up to Mr. Rogers' death there had been a number of complaints made by booking officers regarding the practical problems in carrying out fulsome 4 R checks and requests for more booking officers per shift
- the above complaints were taken to management but never responded to or acted upon
- Sgt. Gillett was aware that a significant portion of 4 R checks were not being done according to the policy but no booking officers had been disciplined because of this and they were told to do the best that they could in the circumstances

[247] In the result, I have determined that the requisite standard did not involve inside cell 4 R checks every 15 minutes as set out in the order (and reproduced at para. 76 herein). Rather, it is my determination having regard to all of the evidence that the standard involved regularly checking on prisoners from outside of their cells with the goal of four per hour but that this would often involve checking less often, such that only three checks might occur in a 60 minute period. I further find that the NCO at the relevant time, Sgt. Gillett was not vigilant in ensuring that the cell checks conformed to the policy as set out in the order. Indeed, booking officers were told

to do the best that they could in an environment that involved not enough on shift at one time. In the result I find that the policy was effectively an aspirational but not a realistic document. In this regard, I refer to and adopt Justice Pomerance's words in *Doering*:

> [105] Policies, in place at the time, directed police to obtain medical assistance for persons severely intoxicated by alcohol or drug. Policies are not the *sine qua non* of a duty of care. They do not have the force of law. They can, however, assist in determining what a reasonably prudent officer would do in like circumstances. … [emphasis added]

[248] I would add that our Court of Appeal has observed that the policy of a police force is an important factor in determining the standard of care a peace officer must observe, but it is not determinative, nor is it to be treated as if it were a statute imposing civil obligations (*Gardner*, para. 75 citing *Roy v. Canada (Attorney General)*, 2005 BCCA 88 at para. 36). Further, the failure to comply with the policy raises questions as to the quality of the judgment brought to bear but does not, by itself, compel a conclusion that the officer failed to meet the standard of care, (*Gardner*, para. 76, citing from *Bergen v. Guliker*, 2015 BCCA 283 at paras. 109 to 111).

[249] Rather than the orders signed by (then) Chief Beazley, I find the 2016 practical realities in the PCF dictate the requisite standard of care. As I consider this I am mindful of Sgt. Gillett's evidence which included confirmation that he was aware of the booking officers' routines and checks and that booking officers were never disciplined for carrying out prisoner checks that clearly fell below policy standards.

[250] Having regard to what I have found regarding the standard of care, I must consider whether Ms. Gardner and/or Mr. Fraser showed a wanton or reckless disregard to the life or safety of Mr. Rogers and that their behaviour amounted to a marked and substantial departure from the standard of care.

[251] Given what I have found regarding the standard of care, it is difficult to understand how what appeal courts have classified as "heedless behaviour" can be made out. That is to say, the checks of Mr. Rogers that Ms. Gardner spoke to, coupled with the video evidence confirms that she carried out checks which I find to be in keeping with the standard of care. As for Mr. Fraser, one must recall that he is shown through exhibits 8 (cell check report) and 10 (video) to, as the Crown has alleged, have falsified three checks of Mr. Rogers. In my view this behavior would have amounted to a wanton and reckless disregard of the life and safety of Mr.

Rogers had Mr. Rogers then been alive. However, as my analysis of causation below reveals, the evidence establishes that Mr. Rogers was in fact deceased before Mr. Fraser's first fraudulent cell check entry thus rendering all three false entries irrelevant from a criminal negligence standpoint.

[252] On the issue of causation I am mindful of the expert evidence of the pathologists. Both Drs. Wood and Chiasson were of the view that Mr. Rogers likely died at 11:41, when he is last seen moving on the video. On the outside, Dr. Wood extended Mr. Rogers' death to having occurred no later than 12:11 and I make this finding from all of the evidence.

[253] From exhibit 8 we know that Mr. Fraser's three false checks are noted as occurring at 12:55, 1:11 and 1:25 on June 16, 2015. Accordingly, even if the checks had occurred, the end result is that Mr. Rogers would have been found dead sooner but he could not have been saved. In the result, the causation analysis referrable to time of death absolves Mr. Fraser for his false reporting.

[254] The Defendants also employ the causation defence to excuse them for allowing Mr. Rogers to be left alone in the cell with the spit hood on. In this regard they say that even if they were criminally negligent in permitting him to be left this way that the Crown has not proven beyond a reasonable doubt that the presence of the spit hood made any difference because it did not materially contribute to his death.

[255] Based on all of the evidence, I find support for the Defendants' argument. In this regard, I return to the evidence of the pathologists. Although Dr. Wood is adamant in her Autopsy Report that Mr. Rogers' death was from asphyxiation and not alcohol intoxication, she moderated her position while on the witness stand. For example, Dr. Wood agreed that a .367 BAC could be a cause of death. She only ruled it out because it is survivable in some cases. Furthermore, Dr. Wood relied on the six months' dated information concerning Mr. Rogers' pattern of drinking, acknowledging that his tolerance may have changed by June, 2016.

[256] Dr. Wood admitted on cross-examination that Mr. Rogers could have died from the alcohol ingestion, alone. She also acknowledged that the photographs of Mr. Rogers (taken after his death) do not show the volume of vomit in his mouth and that removal of the spit hood could have caused the vomit to move up the side of Mr. Rogers' face. Indeed, from the photographs she cannot say that the nose and mouth were submerged in vomit.

[257] In all of the circumstances I prefer Dr. Chiasson's evidence to Dr. Wood's. In this regard I find that his evidence concerning a lack of vomit within Mr. Rogers' mouth or airways is supported by the actual photographs. I found his testimony that even when a person is not deeply unconscious that their reaction would be to breathe the vomit in, at least to the mouth, to be compelling when contrasted with Mr. Rogers' situation. Indeed, when I examine all of the evidence it causes me to conclude that Mr. Rogers must have been deeply unconscious from his alcohol ingestion.

[258] When I consider the evidence of all three experts it is clear to me that a BAC of .367 is sufficient in and of itself to be fatal. Accordingly, given all of the evidence it cannot be said that the spit hood was a contributing factor on a criminal standard. In support of this I repeat what I said about the presence of vomit and add that there was no sign of conjunctivitis. While it is true that Dr. Chiasson accepted that the spit hood could have been a contributing factor, this is not the kind of definitive causation evidence that the Court requires to found a conviction.

[259] When I consider the totality of the lay and expert *viva voce* evidence along with the exhibits and law I find that neither Ms. Gardner's nor Mr. Fraser's acts or omissions contributed to Mr. Rogers' death. Undoubtedly, both accused persons exhibited imperfect behaviour and at times demonstrated poor judgment. With the benefit of hindsight, we now know that Mr. Rogers ought to have received prompt medical attention. Indeed, the reality was that he had deteriorated (due to the effects of the bolus event coupled with his earlier drinking) past the point of being a threat and therefor, the spit hood should have been removed. Presumably because prompt medical attention would have occurred, these actions may have saved Mr. Rogers' life. Nevertheless, the fact that the accused did not enter the cell, remove the spit hood and get Mr. Rogers required medical attention does not in these circumstances, equate with guilt of the criminal charge.

[260] Given all of the evidence and law, I am of the view that the behaviour of Ms. Gardner and Mr. Fraser at the relevant times does not amount to a marked departure from the standard of care of a reasonably prudent booking officer in the circumstances.

[261] I find that this case is distinguishable from the situation in *Doering*. In that case Justice Pomerance found that Cst. Doering turned a blind eye to the risks that would have been apparent to a reasonably prudent police officer. Cst. Doering handcuffed and placed Ms. Chrisjohn, whom he knew to be extremely high on

methamphetamine, in the back of his police vehicle. He did not see to it that she got timely medical attention and Ms. Chrisjohn died of a heart attack. Among other things, Justice Pomerance found that Cst. Doering knowingly misled OPP officers concerning the victim's condition. She concluded that the officer demonstrated a wanton and reckless disregard for Ms. Chrisjohn's life and that his conduct created a risk that "medical assistance would be even further delayed". She ultimately found that his conduct was a contributing cause of the victim's death.

[262] I find this case more in line *R. v. Wood*, 2017 ONSC 3239. In this case an engineer certified the structural integrity of a mall that collapsed, and resulted in the deaths of several people. In particular. Mr. Wood failed to investigate the integrity of a particular beam which later caused the mall to collapse. Justice Gareau acknowledged that although certifying that the mall was safe was poor judgment, the engineer's actions did not show a wanton or reckless disregard for the safety of others:

> [318] In my view, this is crucial evidence as to the standard of care expected of a reasonable engineer in the circumstances and important commentary on the consideration of whether the conduct of Robert Wood showed a marked and substantial departure from that expected of a reasonable engineer in the circumstances. Dr. Saffarini's evidence is that it is inconceivable that an engineer would not notice the deterioration but it is conceivable that an engineer would notice the deterioration and not deem it to be a safety concern. In other words, it is conceivable that even if Robert Wood saw the level of corrosion and deterioration in the mall he could have still concluded that it was safe. In Dr. Saffarini's opinion such a conclusion would have been poor judgment; it would be a conclusion of the engineer based on poor judgment but a judgment not applied out of malice.
>
> …
>
> [330] It is not difficult to conclude on the totality of the evidence that Robert Wood failed to do many things that would be expected of a reasonable engineer in his 2009 and 2012 inspections of the Algo Centre Mall in Elliot Lake, Ontario. Mr. Wood did not scrape beams to get the best view of the steel members. Mr. Wood did not do testing with calibres or ultrasound equipment to determine loss of section in the beams although these instruments were available to him to do the testing. At times Mr. Wood inspected steel members from floor level when he should have used a ladder to view the steel member from an arm's length distance which is the preferable practice to get the vest view of what you are inspecting. As Dr. Ghods put it, "you can't inspect what you can't see". Mr. Wood failed to inspect Beam 1 at gridline 16 in 2012 although he identified this area as an area of concern with respect to water infiltration in his 2009 report. Mr. Wood did not review his 2009 report resulting from his inspection of the mall when he inspected the mall in 2012 and produced the May 3, 2012 report. Clearly, Robert Wood did not observe in

> April 2012 what Dr. Saffarini and Dr. Ghods observed in July 2012, and it is difficult to understand or appreciate why that is.
>
> [331] These facts must be considered against the definition of criminal negligence as set out in s. 219(1) of the *Criminal Code* and the jurisprudence that guides the court as to what constitutes criminal negligence in law. The requirement that the Crown must prove beyond a reasonable doubt on what Robert Wood did or omitted to do he showed wanton or reckless disregard for the lives or safety of other persons elevates the test above that required for civil negligence. In criminal negligence a mere departure from the standard expected of a reasonably prudent engineer is not sufficient to attract penal liability. Wanton or reckless disregard for the lives and safety of others must be proven. As noted in the jurisprudence, this elevated standard requires proof of an "unrestrained disregard for the consequences or "a complete disregard for the consequences of one's action". [emphasis added]

[263] Returning to *R. v. Gardner* at para. 81:

> [81] The jury must also understand that the acts or omissions of the accused amounted to a significant contributing cause of the victim's death (*R. v. Nette*, 2001 SCC 78; *R. v. Maybin*, 2012 SCC 24).

[264] Once again, on all of the evidence I cannot say that Ms. Gardner's and/or Mr. Fraser's acts or omissions of Mr. Rogers amounted to a significant contributory cause of his death. In this regard, I find similarities with the causation analysis I set out in *R. v. Hoyek*, 2019 NSSC 7:

> [68] In determining whether a person can be held responsible for causing death, it must be determined whether the person caused death both in fact and in law. Factual causation demands an inquiry into how the victim came to his or her death, in a medical, mechanical or physical sense, and the contribution of the accused to the victim's death. Legal (imputable) causation is concerned with the question of whether the accused person should be held responsible in law for the death that occurred. See *R. v. Nette*, 2001 SCC 78, [2001] 3 S.C.R. 488, at paras. 44-45; *R. v. Shilon* (2006), 240 CCC (3d) 401, at para. 21 (Ont. C.A.).

[265] In the result I acquit special constables Cheryl Gardner and Dan Fraser of the charged indictable offence. While the death of Corey Rogers is sad and tragic, it did not come as the result of criminal negligence.

Chipman, J.