Release Date: April 27, 2009

MANITOBA

The Fatality Inquiries Act

Report by Provincial Judge on Inquest

Respecting the death of: ALAN EARLE RUPERT

APPEARANCES:

Mr. Neil Peterson, Inquest Counsel
Mr. Robert McDonald, for the police officers
Ms Kimberly Carswell, for the Winnipeg Police Service
Mr. Martin Pollock, for the family
Mr. Sarantos Mattheos, for the Winnipeg Regional Health Authority
Mr. David Cordingley and
Mr. Ross McFadyen, for the property owner

An inquest respecting the death of Alan Earle Rupert having been held by me on the 6th, 7th, 8th, 9th and 10th days of October 2008 at the Law Courts Complex, 408 York Avenue, Winnipeg, Manitoba, Courtroom 316, open to the public. The last written submissions by counsel were received on the 14th day of November, 2008, which completed the inquest. I hereby report as follows:

The name of the deceased is ALAN EARLE RUPERT (a.k.a. Sonny) born on the 23rd day of December 1957.

The deceased came to his death on the 13th day of February 2005 at 00:20 hours at the Health Science Centre, Winnipeg, Manitoba, where he was an inpatient from the 7th day of June 2004, the date of his accidental fall down a flight of stairs resulting in a cervical spine fracture and his quadriplegia. He was hospitalized as an inpatient for these injuries until he died.

The immediate cause of death was aspiration pneumonia due to a consequence of quadriplegia due to a fractured cervical spine sustained as a consequence of the fall on the 7th day of June 2004.

The hospital inadvertently on the 13th day of February 2005 released his body to the Bardal Funeral Home without informing the Office of the Chief Medical Examiner ("OCME"). The OCME became aware of the case on the 15th of February 2005 when a member of the Winnipeg Police Services contacted the Office regarding Mr. Rupert's death. That same day inquiries were made and it was learned that Mr. Rupert's body was at Bardal Funeral Home, that the body had been embalmed and the funeral was to take place the following day. As a result arrangements were made for the body to be examined externally on the 15th of February 2005 at the funeral home. At this stage it was impracticable for the examination to extend to an internal examination.

Now shown to me and identified by my initials and signature and forming part of my report is SCHEDULE A, a schedule of all Exhibits required to be filed by me.

Now shown to me and identified by my initials and signature and forming part of my report is SCHEDULE B, a schedule listing the witnesses called, with a synopsis of the testimony of each of them.

Now shown to me and identified by my initials and signature is SCHEDULE C, a list of appearances of counsel granted standing at the inquest and participating in the inquiry, a statement of the circumstances as I find them from the testimony of the witnesses, the exhibits as filed and submissions by counsel.

I hereby make the recommendations as set out in the attached SCHEDULE D now shown to me and identified by my initials and signature.

DATED at the City of Winnipeg, in Manitoba, this day of April 2009.

_____

Judge T. Lismer

Copies to:
Dr. A. Thambirajah Balachandra,
Chief Medical Examiner (2)
Chief Judge Raymond E. Wyant,
Provincial Court of Manitoba
The Honourable Dave Chomiak,
Minister Responsible for *The Fatality Inquiries Act*
Mr. Jeffrey Schnoor, Q.C.
Deputy Minister of justice & Deputy Attorney General
c/o Ms Lisa Thierjer
for the A/Director of Regional Prosecutions
Ms Aimee Fortier
Executive Assistant and Media Relations, Provincial Court
Mr. Michael Anthony
Exhibit Control Officer, Provincial Court
Mr. Neil Peterson, Inquest Counsel
Mr. Robert McDonald, for the Police Officers
Ms Kimberley Carswell, for the Winnipeg Police Service
Mr. Martin Pollock, for the family
Mr. Sarantos Mattheos, for the Winnipeg Regional Health Authority
Mr. David Cordingley, for the property owner
Mr. Ross McFadyen, for the property owner

SCHEDULE A OF EXHIBITS IDENTIFIED BY MY INITIALS AND SIGNATURE AS PART OF THE PROVINCIAL JUDGES REPORT RESPECTING THE DEATH OF ALAN EARLE RUPERT

Exhibit 1 A binder of 49 photographs prepared by the Forensic Identification Section of the Winnipeg Police Service, including exterior and interior portions of the dwelling house located at 704 Magnus Avenue, Winnipeg, Manitoba. This Exhibit includes the stairway of this residence where the accidental fall by Alan Earle Rupert while in the custody of Dennis Pedersen and Matthew Freeman of the Winnipeg Police Service resulting in the severe injuries to the deceased, his hospitalization for them and eventual demise. This Exhibit also includes various articles of clothing taken from the deceased and photographs of the naked body of Alan Earle Rupert.

This Exhibit was marked as Exhibit 1 as part of the testimony of Dennis Pedersen on the 6th of October 2008. (Page 64 of the transcript of the evidence on the 6th day of October 2008.)

Exhibit 2 was marked as an Exhibit on the 8th day of October 2008 during the testimony of William Frank Ralph. (Pages 6, 11 and 12 of the transcript of 8th of October 2008.) This Exhibit comprises four drawings prepared by William Frank Ralph:

1. drawing of view of stairs ascending to the second floor;
2. drawing of overhead view of 704 Magnus;
3. drawing of west wall stairs ascending;
4. drawing of overhead view of 704 Magnus.

Exhibit 3 was marked as an Exhibit on the 10th day of October 2008 as part of the testimony of Patrol Sergeant Ronald Bilton, Officer Safety Coordinator for the Winnipeg Police Service and a member of the Winnipeg Police Service for 19 years working in a number of different divisions including General Patrol, Criminal Investigations and Human Resources as an Applicant Investigator, and his curriculum vitae (page 50 of the transcript for that date).. He was born and raised in Winnipeg and completed a Bachelors Degree in Psychology and Criminology from the University of Manitoba in 1983.

Exhibit 4 is a Use of Force Analysis prepared by Ronald Bilton marked as an Exhibit as part of his testimony on the 10th day of October 2008.

This report highlights the initial Use of Force Application by the officers within suite #1 as well as the escort from the suite down a set of stairs to the front of the residence. It comprises of a Pre-event Analysis, Event Analysis, Post Event Analysis and concludes:

"In conclusion it is my opinion the actions of the officers with respect to the initial contact and use of force were appropriate and reasonable. With respect to the relative positioning of the officers during the escort the actions of the officers were again reasonable and appropriate."

Part of his Event Analysis includes the following:

"The officers then describe further Mr. Rupert's level of intoxication. For this reason alone it would be appropriate to handcuff and [sic] individual who was being arrested. The actions of both officers to this point in my opinion are both reasonable and appropriate."

"The second phase of the incident involves the escort of Mr. Rupert from the suite on the second floor. There are a number of considerations here which must be examined. In my opinion the choice to cuff Mr. Rupert is reasonable and appropriate. Officers are taught only to cuff subjects with the hands behind the back. This places the subject in a position of disadvantage and eliminates his or her ability to use the cuffs as a weapon. Handcuffs placed in front of a subject may be used as an instrument to choke an officer and the subject would be in a better position to strike at officers if the cuffs are placed in the front."

"Mr. Rupert [sic] level of intoxication would be the next consideration as the officers had to descend a set of stairs from the second floor. A determination would have to be made as to the subject's ability to support his own weight to enable him to

descend a staircase. Typically if officers face the scenario in which a person is unable to do this, officers are advised to have Winnipeg Ambulance attend. A person that could not support his own weight may be in need of medical attention and ambulance would be called in any event. The officer clearly felt this was not the case as Mr. Rupert had managed to struggle with enough force to resist dropping an object in his hands. Once on his feet he had to be escorted through the suite some distance to the top of the stairs. This no doubt would be sufficient time to formulate an opinion as to whether he was capable of walking under his own power but with assistance."

"The stairs are the next consideration for the officers and their respective positioning in relation to the subject Mr. Rupert. It appears the stairs and the environment in general limited the officer's choices in the descent. The stairs precluded the officers from being on either side of Mr. Rupert as they were too narrow. For this reason Constable Pederson placed himself in an appropriate position that being Mr. Rupert's right side slightly behind him. This is referred to as the escort position. It enables an officer to be in control of a subject but still be able to assist a person in walking and maintaining balance. The position also makes it more difficult for a subject to lash out with his head for example. An officer with his hand on the subject's upper arm can prevent a subject from quickly turning and allows for the officer to feel for resistance. For example if a subject flexes his arm very tightly an officer may interpret this as an increase in his or her level of resistance."

"The next consideration would be the relative position of the second officer. In this case Constable Freeman was positioned behind Mr. Rupert. The advantage is that the officer is not vulnerable to attack launched by a subject whose legs would be in a position to kick to the head of the person descending the stairs in front of him. The disadvantage is that a subject bent on escape may interpret this as an opportunity to attempt escape. The idea that an officer in front of a subject could potentially prevent a fall is I believe, unreasonable from a risk perspective. To be close enough to catch a person of Mr. Rupert's size without injury to both Mr. Rupert and the officer is unrealistic.

The risk of putting yourself within what is referred to as the reactionary gap would be unreasonably high. To clarify, the reactionary gap is an area which is close enough to a subject that would allow him to kick and make contact. This area is generally about six feet. The only other alternative in this environment which could lessen the risk would have been for Constable Freeman to move far enough ahead and maintain that distance to prevent Mr. Rupert from having the ability to kick at him. This would place him in a position where he would be unable to catch Mr. Rupert if he fell. The idea that Constable Pederson could prevent a man of Mr. Rupert's size from falling I believe is also unrealistic. For these reasons I find the actions of both officers in this case reasonable and appropriate to this point. The choice to walk Mr. Rupert from the suite to the cruiser car was made by the officers who no doubt had made similar choices many times in their respective careers. To think that an ambulance should be called in every instance where an intoxicated individual has to descend stairs would constitute an abuse of that resource."

In Post Event Analysis of the Use of Force Sergeant Ron Bilton said:

"The last consideration of course occurred after Mr. Rupert's fall. Officers are required by policy to provide medical assistance to any person in their custody if they receive a request. It appears officers made an assessment at the base of the stairs and determined it was safe to move Mr. Rupert. Immediately upon recognition of his deteriorating condition Mr. Rupert was un-cuffed and placed in the recovery position. Medical attention was summoned at this point. This in itself is a judgement call on the part of the individual officers and impossible to second guess. Un-cuffing a subject at the point where his level of consciousness has changed would be recommended in the event an officer would be required to perform other life saving first aid."

Exhibit 5 Documents provided by the Office of the Chief Medical Examiner marked the 10th day of October 2008 (page 99 of the transcript for that date). All the documents provided by the

office of the Chief Medical Examiner are compiled in the binder marked as Section 1 under tabs A1 to A12 both inclusive.

Exhibit 6 Three binders of medical history of Alan Earle Rupert. They are detailed in the Index of Section I as C1 to C25 both inclusive.

Exhibit 7 Handwritten notes of Constable Wayne Davis with entries from the 4th of June 2004 to the 4th of July 2006. Constable Melvin Wayne Davis testified at the Inquest on the 7th day of October 2008 (pages 64-74 of the transcript on the 7th of October 2008).

Exhibit 8 Death Package and forms marked as an Exhibit on the 10th of October 2008 (page 100 of the transcript).

Exhibit 9 Notification of Death forms of the Health Sciences Centre, partially completed and unsigned.

SCHEDULE B OF WITNESSES
and Synopsis of their Evidence
Attached to Provincial Judges Report
Respecting the Death of Alan Earle Rupert
(the salient portions of the testimonies of each witness is quoted verbatim from the transcript of proceedings for that day, with page numbers indicated to facilitate cross-references)

Witness No. 1: **Dennis Pedersen** who testified on the 6th of October 2008.

He is a constable with the Winnipeg Police Department with 12 years experience. (Pages 6 and 7) – "That night we received a call indicating that there was two, two males on a rooftop at 704 Magnus . . . Just after midnight. . . . We then go to the back of the house and observe one male on the roof." (Page 8) – "there's a number of boxes and other articles stacked up, and . . assumed that was the way that he, he got onto the roof". (Page 9) – "didn't know who this individual was at the time . . We were trying to engage him in a conversation as to what he was doing up there. . . . He then comes back to us and says . . . I'm here to have sex with my wife. What's it to you?" (Page 10) – "After a short conversation, it was, obvious to us that he wasn't going to be climbing down, so then we then went inside through the front door. . . . We entered through the front and we had a brief conversation with, with the lady that lived in that suite, who turned out to be Theresa Sinclair." (Page 11) – "She just quickly related that the person out there was her now ex-boyfriend, that they had just broken up that week." (Page 12) – "She indicated that he had, he had tried, or he had broken into her, her suite that week and that that was why she had then screwed shut all the windows in her, in her suite. And the other thing, too, was that she said she was extremely fearful of him - - when he did drink, or do pills or a combination of." (Page 13) – "saw him out the window. . . .Sitting or crouching. At that time we were yelling at him to lie down, to lie down on his stomach, just because at that point we didn't know if there was going to be any weapons involved." (Page 14) – the window "had been screwed down with what I believe were drywall screws. Theresa Sinclair then gave me a hammer, like a claw hammer, so I could pull out the screws so I could get the window open. So we got the window open. As soon as the window was opened up, Mr. Rupert then came through the window rather quickly and forcefully." (Page 17) – "we're trying to force him onto his stomach we then notice that there's a black object in his hand. . . we're kind of using his momentum at the same time to force him onto the floor. But at the same time we can feel that he's resisting quite a bit." (Page

18) – “he’s got something in his right hand. We’re yelling for him to drop it.” (Page 21) – “it was a multi-tool . . . like a Swiss army knife.” (Page 23) – “advised him that he was being arrested for break, enter or some other similar offence.” His response, “he was just kind of muttering . . . he was just kind of trailing off, and then he didn’t finish that sentence. We then lifted him up. He was quite intoxicated.” (Page 24) – “the smell of alcohol . . . he was slurring . . . His unsteadiness on his feet. And at the time, too, he had froth - - quite a bit of froth around his mouth. . . . I was using my left arm to hold onto his right arm, as he’s handcuffed behind his back.” (Page 25) – “my understanding is that any person that’s - - that you’re taking into custody . . . or if there’s been any signs of violence or history of violence, they’re to be handcuffed at the rear.” . . . As we’re escorting him out into the hallway . . . a fairly narrow hallway. As well as the stairwell was quite narrow.” (Page 26) – “a narrow set of stairs”. Unable to stand two abreast on the stairs, that is right beside the person. There was no discussion as to how he would be removed from the building. (Page 27) - They proceeded down the stairs with Mr. Rupert “and then myself, with a hold of Mr. Rupert’s arm . . . and Constable Freeman was right behind me. I was using my left arm and I had a firm grip just above his elbow. . . . the bicep area. (Page 28) – navigated the first three stairs down to the landing” without difficulty, “then you have to make a right-hand turn and head down the, the longer flight of stairs – in a fluid motion. There was no stops. But we’re going at a nice, slow, leisurely pace.” Rupert being slightly lower than him and (Page 29) and while “still grasping on his - - above his elbow, on his right hand” with the officer’s left hand” there was no trouble getting down the hallway and to the landing except “the fact that he was intoxicated - - and unsteady on his feet. He wasn’t resisting. . . . he was swaying on his feet. . . .With me holding firm onto his arm, I was able to keep him in a forward, forward direction - - without him falling.” (Pages 30 and 31) – “Then approximately four to six stairs down, as I’m holding Mr. Rupert, I then feel a jerk from Mr. Rupert coming from his, from his arm and body. . . .And then at that same instant his momentum then starts to go forward. Then at that same instant, as well, I then end up slipping on a step. . . . And at that same instant my foot ends up rolling over and then, unfortunately, at that time, with the momentum and Mr. Rupert going forward, I wasn’t able to hold onto his arm any longer. . . this was all in, in this, you know - - Split second. - - a blink of an eye. . . . I then, to prevent me from falling forward, I ended up having to brace myself forward and I was able to grab onto the railing . . . and I didn’t fall.” And Mr. Rupert fell the rest of the way down the stairs. As shown in photo number 7, (Page 32) – “As Mr. Rupert fell forward, the door, which had been propped

open on an angle - - he ended up making a glancing blow on the open door. . . there's some kind of stick or whatever propping the door open . . . Mr. Rupert ended up hitting the, the open door a glancing blow . . . with his head." Constable Pedersen testified that he didn't fall or completely fall or land on Mr. Rupert and was able to steady himself on the stairway. (Page 33) - Where an ambulance attendant said he heard at the scene that an officer had fallen on Mr. Rupert or fallen down the stairs that never happened. "Absolutely not. Myself and Constable Freeman, we then attended to the bottom to check on Mr. Rupert. . . . we were asking him, Are you okay? Are you hurt? Just - - we were both constantly repeating those questions to him. . . .he was muttering, Ah, fuck. And then at the same time he was, he was moving his head and we were then able to see on his, I think it was his left temple, he had what I would call like road rash. . . . Which we obviously assumed was from when he hit his head on the door when he fell." (Page 34) – It was assumed from Mr. Rupert's responses which were "similar responses to other questions beforehand, where he obviously wasn't answering fully . . . it was consistent with what we had received upstairs. And he wasn't indicating that he was hurt, he wasn't yelling out about any pain. So at that point we then lifted him up." (Page 35) – "So at that point it's myself and Constable Freeman who lift him up and are holding him up. . . we'd only taken a couple of steps, but I noticed that he wasn't putting any weight on his legs anymore. And, as well, he was now going in and out of consciousness." (Page 36) – "we then put him down immediately into the recovery position. . . kind of, fetal, on the side . . . we called an ambulance. And I had returned to speak to Ms Sinclair." (Page 38) – "And shortly after that the ambulance came. Myself and Constable Freeman, we then went with Mr. Rupert to the HSC. . . .the ambulance arrived" about the time "I'm speaking with Theresa Sinclair after the incident, at 12:33 a.m." (Page 42) - They arrived at the hospital "shortly after 1:00 a.m." (Page 43) – "the doctor was concerned that he may have sustained paralysis. . . . at 1:45, we met with another unit that came down to relieve us." The weather on that particular day, "It had been raining quite a bit that evening." (Page 44) - "the stairs are in bad working order. However, working in the north end we kind of get accustomed to a lot of buildings being in, in bad working order . . . I would have been wearing my summer issue" of footwear. (Page 45) – "Over the years we've escorted quite a few intoxicated persons and at that point this was another routine intoxicated accused." So the situation or his condition in Constable Pedersen's mind didn't call for any extraordinary or out of the ordinary measures to remove Mr. Rupert from the house. Putting him in leg irons or escorting him down in some other fashion "would have made it worse.

Because of his intoxicated state, and he had been hostile initially." (Page 46) – Carrying him down the stairs, "I believe that would have made things worse. To have Officer Freeman walk in front of Mr. Rupert and remove him in that fashion "would have put Mr. Freeman in a very awkward and unsafe position . . . Just in experience, we've seen where intoxicated persons have, for no reason, they've lashed out and kicked, and Mr. Freeman would have been in a perfect position to be kicked." Constable Pedersen indicated he was not aware of any other technique that could have been used to escort him down the stairs. (Page 47) – "I can't think of any, any policy or, or anything" in his training that would have led him to a different way of escorting him or removing him from the building. Mr. Rupert would have lost his footing first and him starting to fall would have pulled Constable Pedersen forward. (Page 48) - It is not possible that it was the other way around that the witness Pedersen lost his footing resulting in some accidental pushing Mr. Rupert forward because "I felt the jerk and the momentum first from his body."

(Witness Pedersen is cross-examined by Martin Pollock – pages 53 and following from the transcript)

(Page 54) – Constable Pedersen's understanding, in speaking with Theresa Sinclair, was that Mr. Rupert had been drinking and had been consuming pills, and from her had correct working assumption that he was intoxicated. (Page 57) – They tracked up the stairs with wet footing, on the vinyl stairs. (Pages 59 and 60) –The stairs were covered with a plastic runner which over time stretches and then loses the grip to whatever material that is hugging on to the steps and even if tucked in it is not going to be snug on the stairs. This created a condition when lent itself to a slip taking place. "It was absolutely a contributing factor." (Page 61) – "after having viewed the photos, noticing that the stairs didn't appear to be tacked down at, at the lip, and also, over time, with this kind of plastic stretching, looking at it now and also then, when I first looked at the pictures, it was quite obvious as to how bad of an idea putting that kind of runner on, on the steps, and then with it being wet," (Page 63)- At the edge of the vinyl it wasn't tacked down and appeared to have been stretched out and therefore not as secure as it perhaps ought to have been. (Page 69) – Once the handcuffs were on him, he was a compliant individual who was intoxicated. (Page 72) – "He was very unsteady." (Page 80) – Constable Pedersen did not use dialogue during the escort with Mr. Rupert in walking. (Page 81) - That is didn't say to Mr. Rupert, we're going to go down a stairwell and I'm concerned for your safety here, so let's go down very slowly and let me know if I've got you tight

enough. Mr. Rupert was not wearing a belt around his waistband that was noted. (Page 83) – It is fair to say that there was no police policy on escorting people down stairs, nothing specific. (Page 84) - No training material that would have anything specific to escorting downstairs. Escorting Mr. Rupert down the stairs and holding onto him with a firm grip. (Page 87) – Constable Pedersen held onto Mr. Rupert by looping his fingers around his arm at the elbow area; "above the elbow and on the bicep, but not to the point where I'm looped, where you get into too close quarters." (Page 88) – There was a handrail along the stairway. Constable Pedersen was the one who occupied the position closest to the handrail. (Page 90) – The purpose of a handrail is to stabilize an individual who is going down the stairs. Constable Pedersen made a decision not to use it. (Page 91) – There is no policy that says you must hold a handrail. (Page 93) – The stairs covered with plastic matting that was slippery and were "a contributing factor" to the fall. (Page 94) – It wasn't a carpet that was slipped on but it was plastic. (Page 96) – Constable Pedersen had felt a jerking motion and "I can only assume that a loss of footing occurred". (Page 97) – Constable Pedersen didn't see him lose his footing. (Page 100) – "I slipped over on my left foot. . . .It slipped down a stair" while not holding onto the handrail. (Page 104) – When the officers went down the stairs after the fall and spoke with Mr. Rupert, they were asking him if he was okay. They didn't ask him if he could move his feet. They didn't take an instrument such as a pen and run it up the shoeless Mr. Rupert to see whether or not there was a response from his feet, never asked Mr. Rupert if he could move his fingers, never asked Mr. Rupert whether or not he had feelings in his lower extremities and never asked him whether or not he could get up on his own and walk. (Pages 105-106) – And in terms of assessing whether or not somebody in custody had broken his neck and had been rendered a quadriplegic or paraplegic, one of the things that you must do is ask him whether or not he has feeling in his limbs. "Knowing what I know now, that's probably a good idea." But he didn't know that then. "we were assessing him on the assumption that we were dealing with a head injury." Constable Pedersen had taken St. John Ambulance training which did not include spinal injury specifically and had not certification that involved spinal assessment. One of the recommendations on this experience is that all officers be given appropriate training in terms of assessing and recognizing a potential spinal injury on someone in custody. (Page 109) – His assessment was that Mr. Rupert did have some power in his limbs for those first three steps, "when he's on his feet" and he did not know whether or not the movement completed his quadriplegia. (Page 111) – As to using the handrail to stabilize it is, "depending on the situations, you have to have your

dominant hand free for your sidearm." (Page 112) - But in this particular situation he would have preferred to have his right hand on the handrail to stabilize himself while descending with Mr. Rupert. (Page 113) – The Use of Force form was filled out because of the distraction blows that were administered at the top of the stairs before the movement towards the stairs and removing the multi-tool from Mr. Rupert's hand.

(Examination of Witness by Ms Carswell – pages 119 – 124)

The reason for handcuffing someone to the rear of their body as opposed to the front is that "any person that's being taken into custody or that's been violent, policy dictates that you handcuff them to the rear; as well as the fact that for officer safety-wise, if they're handcuffed in the front, it just leaves too many positions of disadvantage, where they could use the handcuffs as a weapon, of they could choke you or attempt to escape." (Page 121) – Although one of the options as they moved forward was to loop arms with Mr. Rupert. This would be for the officer's safety. "If you're looping, then the chances of, of him being able to head butt you because now you're in a lot closer quarters." (Page 122) – It is impracticable to train a police officer for every single scenario such as escorting intoxicated person down a set of stairs because "you can never train for the exact same situation." (Page 123) – The stairs themselves were in such a condition that they were not able to walk two abreast down the stairs.

(Examination by Mr. McDonald)

(Page 124) – There was no forewarning of any problem in escorting Mr. Rupert down the stairs.

<u>Witness No. 2</u>: Matthew Freeman who testified on the 6th & 7th days of October, 2008.

His testimony on October 6th is covered in a transcript for that date from pages 128 and following and corroborates or amplifies the testimony of Witness Constable Pedersen. (Pages 143-144) – After handcuffing Mr. Rupert they were able to get him up on his feet, he was able to stand up, he was walking. "At that point it became fairly apparent that he was intoxicated . . . and then just the glossy kind of bloodshot eyes and the speech . . . there was definitely some slurring in his speech pattern." He did not notice any frothing around his mouth. "He was walking on his own" while escorted.

(Page 146) – "He wasn't struggling or resisting arrest at that point." (Page 148) – When they got to the landing and turned to go down the stairs, "I was right behind them. And then they made it approximately halfway down the stairs - - and that's when they both seemed to - - they appeared to lose their footing and slip on the stairs. And then at that point Mr. Rupert fell forward to the base of the stairs." Constable Pedersen "just seemed to kind of go over - - he fell forward. He didn't go down the stairs, but he just kind of went forward, and he seemed to just slip and kind of go over onto his ankle or whatever the case was, but he was able to kind of steady himself." He never actually fell and went down a stair or two before he stabilized himself. "I think he grabbed onto the railing or he just - - however his position on the stairs there, he was able to stop his descent." (Page 149) - As to who slipped, "it appeared they both did. . . . I wouldn't attribute it to one more so than the other. (Page 150) – "I wasn't . . . focused on their feet as I was walking down - - the stairs." They both sort of simultaneously seemed to slip. (Pages 151 – 142) - When Constable Freeman got to the bottom of the stairs he noticed a scrape or something on Mr. Rupert's head, "I noticed, like, like, a small - - abrasion on, like, the left temple area. . . . I see his head make contact with the door." When they got down the stairs, "His eyes were open, and he was still kind of – he seemed to be like mumbling to himself, almost talking, and there was some expletives." As to any injury, "the only thing we noted at that point was just a small abrasion on the temple area. . . .We asked if he was okay, if he was in any pain" to give us an indication of any injury during the fall but he did not indicate that he was hurt in any fashion. As he went down his hands were handcuffed behind his back. (Pages 153 – 154) – "Just the nature of the fall . . .I wasn't concerned, like, whether it would be a serious head injury or a serious neck or spinal injury. . . .my basic concern is he would have broken his nose or . . . something along those lines." Officer Pedersen definitely did not fall on top of Mr. Rupert. "That didn't happen". "It was raining" that evening.

(Testimony of Matthew Freeman on the 7th day of October 2008 and reference to transcript is now to the transcript on the 7th of October 2008.)

Pages 1 – 22 cover the testimony on examination by Martin Pollock, Kim Carswell and R. McDonald. (Pages 1 & 2) – Constable Freeman's deduction was that Mr. Rupert had climbed up on the roof using those boxes that were stacked at the side of the house that were about waist level. (Pages 8 & 9) – After he was handcuffed he was brought to his feet, he was walking

on his own, he was not falling. "He seemed a little bit unsteady, obviously, somewhat under the influence of alcohol, but I wouldn't describe it as falling from side to side." He had enough energy to get up on the roof, enough equilibrium to stay on the roof, enough equilibrium to get himself through the window without difficulty and enough equilibrium to walk on his own. Constable Freeman did not observe any problem with him walking down the hallway. This was going to be an ordinary escort of a guy who was impaired or intoxicated down a flight of stairs to a waiting cruiser car. That is a routine arrest. (Pages 10 & 11) – The escort towards the stairs is going exactly as it should according to the textbook. Then there is a fluid motion down to the middle of the stairwell and the next thing that happens is there is a slip and Mr. Rupert goes headfirst down the stairwell - in a split second. (Page 13) – Up to the time when Mr. Rupert fell down the stairs he could walk on his own, "he was intoxicated and seemed somewhat unsteady on his feet, but he had no trouble walking on his own power." Prior to the fall he appeared to have full use of his limbs. (Page 14) – In terms of a safe escort, the mandate is for a police officer to make sure that he has a firm grip, an appropriate grip on his prisoner and escorting a prisoner down the stairs who is handcuffed behind his back requires extra care because the danger is that a fellow who is intoxicated can fall down the stairs and not have any hands available to him to break his fall. It is very important to ensure that you do not let go of your prisoner an officer escorting a prisoner down a flight of stairs should do everything possible not to let go of the grip. (Page 15) – He wasn't resisting when he was being escorted. There was, from Constable Freeman's perspective, a slip and a loss of grip.

(Examination by Ms Carswell)

Pages 17 & 18– It was a force encounter with Mr. Rupert, "A force encounter is when we're confronted with a subject or an accused person who's being either resistant or combative with the attending officers." Extra caution would need to be taken because of the presence of a weapon, that being the multi-tool. An intoxicated individual is less predictable than someone sober. Constable Freeman indicated he had many experiences during his career with someone who is intoxicated who may be initially compliant but then become combative later. (Pages 19 & 20) – Constable Freeman's training was for a period of six months plus field training with an experienced officer plus further upgrading training in areas such as first aid, use of force, firearms and qualifications. (Pages 21 & 22) - In this particular case, given the environment they had to work with and given the encounter

with Mr. Rupert there was no other way they could have escorted him or that he should have been escorted down the stairs.

<u>Witness No. 3</u>: Henry Sobczak who testified on the 7th day of October, 2008.

(Examination by Mr. Peterson) (Pages 32 – 38)

He had rank of Patrol Sergeant with the Winnipeg Police Service and has been a police officer for almost 28 year and on that date was the Street Supervisor. (Pages 31 & 32) - "On the 7th of June, 2004, at approximately 12:33 a.m., I received a call to attend 704 Magnus Avenue regarding an injured male, . . . The information was the male was unconscious and then conscious at one point." (Page 33) – "I did not observe the male in handcuffs and Winnipeg Ambulance personnel were attending to this male by placing a C-collar around his neck . . . He had no handcuffs on. . . . I spoke with Constable Pedersen and asked him what had happened, and Constable Pedersen's reply was he was escorting the male down the stairs in 704 Magnus when he slipped and the male took a header down the stairs into the door at the bottom of the stairs. . . And Constable Pedersen advised me that he didn't fall himself, he had just stumbled along the stairway." (Pages 34 & 35)– "I observed that the interior door into the building was propped open with a broom handle and it was supported under the doorknob. . . . The stairs were very narrow and there was a vinyl runner along the steps, and this was poorly secured. And there was carpeting on top of the landing at the top of the stairs . . . I received a pair of white runners from a female identified to me as Theresa. She advised they belonged to a male named Alan." The runners were placed in a plastic bag and into the officers' trunk. He believed these were the injured person's shoes.

(Examination by Mr. Pollock) (Pages 38 – 42)

Constable Pedersen advised me he was escorting the male down the stairs of 704 when he slipped on the carpet. It was understood that "he" referred to Constable Pedersen. (Pages 39 & 40) - At no time did Constable Pedersen tell Sergeant Sobczak that he heard a jerking feel, or about a feeling of a jerk coming from the male. Interpretation is that the escort was coming down the stairs without problem until Constable Pedersen slipped. It was losing his footing that caused the male to go down the stairs basically. The main set of stairs was covered by a poorly secured vinyl runner. There was nothing

securing the vinyl riser to the edge of the stair where one steps to go down the stairs and based on experience, considered a hazard. He was unable to disagree with Constable Pedersen's version of the cause of the fall that is that Mr. Rupert lost his balance first causing Constable Pedersen to lose his balance and stumble.

<u>Witness No. 4.</u> David George John Mann testified 7th October 2008.

(Examination by Mr. Peterson) (Pages 48-56)

He is a police officer with Winnipeg Police Service since December of 2000. He attended 704 Magnus at about 12:35 a.m. The male was in "the recovery position on his side, I believe, and ambulance was on its way. . . .At 12:58 a.m., obtained a statement from Lloyd Genaille . . . At 1:12 a.m., my partner, Constable Davis, obtained a statement from the victim, Theresa Sinclair, which was subsequently completed at 1:32 a.m. . . . At 3:22 a.m., we were asked to go back to the Health Sciences Centre to relieve Echo - - Constable Freeman and Pedersen. At that time, we advised that the attending doctor is Dr. Peterson. At 3:30 a.m., Mr. Rupert was turned over to us. . . . At 3:47 a.m., we were escorting him to the CT scan, and that's when I spoke to Dr. Peterson, who advised that he may have - - that Mr. Rupert may have a neck injury." Certain articles of clothing and pill bottles were seized.

"I overheard the nurse ask Mr. Rupert what happened, to which he stated: I fell. Can I have a smoke? . . .When completing my narrative, I also recalled that there was a second additional comment from Mr. Rupert. Says, Does anyone have a beer?" Dr. Peterson "advised me that the CT scan revealed a T3 and T4 fracture and a seventh left rib. . . . that he's showing no signs of reaction and that he's -- could be paralyzed from the neck down."

(Examination by Mr. Pollock) (Pages 56-62)

Basically there's no policy that says that you don't' offer footwear to a fellow who is being escorted to a cruiser car which is basically left to the discretion of the officers.

(Examination by Mr. McDonald) (Pages 62-63)

Learned Mr. Rupert was on probation.

<u>Witness No. 5.</u> Melvin Wayne Davis testifying 7th day of October 2008. (Pages 63-76 of the transcript for October 7, 2008.)

(Examination by Mr. Peterson)

He will have been a member of the Winnipeg Police Service for eight years in December, 2008. "I was advised by Constable Freeman to attend inside and meet with Pedersen, who was also inside." Pedersen "advised me to take statements and speak with the tenants who were inside. . . . I went to Suite 3 and met with Theresa Sinclair . . . And I took a statement from her. . She gave me some, some background information . . . from 1:12 until 1:32" a.m.

(Examination by Ms Carswell)

Coming down the stairs after interviewing Theresa Sinclair Constable Davis lost his footing on the third step down, on the last stair before the landing. He observed afterwards that the covering was loose on that stair and the nosing of that stair was broken and as weight is put on it that is when he slipped. "As I recall, the stairs in general were just in rough shape."

<u>Witness No. 6.</u> James Donald McKendry testifying 7th day of October 2008. (Pages 76-103 of the transcript for October 7, 2008.)

(Examination by Mr. Peterson)

Employed by Winnipeg Fire Paramedic Service for over 20 years. "I found the patient on the boulevard, laying on his right side, with his hands handcuffed behind his back. . . . Police officers were there. . . .And they had told me that the patient had fallen down approximately six to eight stairs with an officer, after struggling with officers. . . . My understanding was that the police officers had fallen downstairs with this patient and there was some struggling prior to the fall." They arrived at the hospital at 0059 and the notes were taken approximately 20 minutes later after arrival on the scene. He was concerned that there was a head or neck injury but "I was more concerned, actually, for a spinal injury potential. . . . He was hypotensive, so his blood pressure was low." As to precautions taken when there is a suspected spinal or neck injury, "we minimize as much movement of the neck as possible." From his notes, "I was told by one officer that the patient had fallen down some stairs with one of the officers, and the officer landed on top of him at

the bottom of the stairs." The patient was not able to describe to Mr. McKendry what had happened. There was obviously a spinal or cervical injury and "I made note that there were some superficial abrasions at his sternum, his left temporal lobe of the scalp – anterior left elbow, and anterior right ankle and lower leg."

(Examination by Mr. Pollock)

Mr. McKendry did not see any froth coming from Mr. Rupert's mouth. "I arrived on scene at 12:37 and I was at patient's side a minute later, so 12:38." He then had a conversation with the officer to find out what happened and the recollection is that the officer said that he fell down together with an officer beside him and that the officer landed on top of the patient. From his statement, "The patient was laying on his right side with his hands cuffed behind him. I think his knees were bent almost in the fetal position. . . . I asked the officer to uncuff the patient. . . . So we arrived at the hospital at 12:59." They stayed in the resuscitation room for about 20 minutes.

<u>Witness No. 7.</u> Gilbert Debreuil testifying 7th day of October 2008. (Pages 103-118 of the transcript for October 7, 2008.)

(Examination by Mr. Peterson)

Mr. Debreuil was employed by the Winnipeg Fire Paramedic Service in June of 2004. He attended at 704 Magnus Avenue. On arriving at the scene, "There was a police car parked along the curb. There were, I believe, two officers, and a gentleman laying on the boulevard." Mr. Rupert was not responsive to attempted conversation. He was handcuffed but they were removed for the paramedics' purposes. From Mr. Debreuil's statement, "We were told he had fallen down approximately eight or nine stairs. He was being, he was being combative."

(Examination by Mr. Pollock)

He did not recall observing any froth coming from the patient's mouth.

<u>Witness No. 8.</u> William Frank Ralph testifying 8th day of October 2008. (Pages 1-31 of the transcript for October 8, 2008.)

(Examination by Mr. Peterson)

A member of the Winnipeg Police Service for 21 years attached to the Identification Section. He attended 7th June 2004 to 704 Magnus Avenue in connection with an incident involving a male who had fallen down a flight of stairs after being arrested by Winnipeg Police Services and was currently in the hospital in critical condition. "The interior door is a metal clad door and that door was propped open with a broom handle just as it appears in that photograph", number 7. Photograph 19 shows that there is nothing to hold the runner on the landing at the top, allowing it to slip forward and kind of roll down the bottom of the next step downward, with nothing to hold it in place.

Photographs numbered 20 and 21 show the riser with the runner that has slipped approximately six inches with some of it handing down over the edge of the top step.

"The handrail was secure. . . . U attended on the 7th and I arrived at the scene at 11:20 in the evening. . . . a considerable amount of time had elapsed between when this incident had occurred." The width of the stairway would make it impossible for two officers and a suspect to descend the stairs three abreast. It is unlikely or probably not feasible that two people would have difficulty walking down the stairs on the same stair. The photos show that the carpet even though there is a horizontal metal strip securing it to the riser there is still some looseness in the vinyl runner on the stairs which would allow for movement of the vinyl strip horizontally if weight is placed on it such as by someone taking a step on it.

(Examination by Mr. McDonald)

A vinyl runner by itself whether tight or loose is a slipperier surface than a well secured carpet. "I would be very reluctant to put a vinyl runner on a stairway in the fashion that it was on this stairway." That's because from what was observed that constituted a hazard to anyone using that stairway.

This witness prepared four drawings Exhibit 2.

<u>Witness No. 9.</u> Raymond Reimer testifying 8th day of October 2008. (Pages 31-41 of the transcript for October 8, 2008.)

(Examination by Mr. Peterson)

Raymond Reimer, resident at a suite at 704 Magnus Avenue on June 7th, 2004, heard somebody outside. "I opened the door and there was a couple of guys climbing up on the, on the railing and I told them to - - they can't go up there. . . . They told me to F off so . . . I just closed the door and that was it. . . . They were climbing up on my railing on the outside of the steps." They were trying to get up to the roof. He informed them that the police would be called and the two persons told him to go ahead. He understood one of them was Theresa Sinclair's boyfriend. This witness lived on the main floor at the back.

(Examination by Mr. Pollock)

The railing was attached to the steps going into the back door.

<u>Witness No. 10.</u> Perry Arnold Baptiste testifying 8th day of October 2008. (Pages 41-75 of the transcript for October 8, 2008.)

(Examination by Mr. Peterson)

Perry Arnold Baptiste lived at 704 Magnus Avenue in a suite on the upper floor on June7th, 2004. Theresa Sinclair also lived on the upper floor.

Theresa Sinclair came to his door at around midnight and told me there was someone on the roof. She stayed in the witness' room until the police came. When the police came they borrowed a hammer from downstairs. "And then they went in the room and opened a window." He recognized the man handcuffed by the police as Alan Rupert. He had seen him there before with Ms Sinclair. He lost sight of them after they came out of the room and had turned to go down the hallway and down the stairs. "After that I heard something like somebody falling down." Ms Sinclair was still in his room. When it was raining outside and you come in with wet feet the vinyl would be slippery and you would use that railing so that you would not slip.

(Examined by Mr. McDonald)

Alan Rupert was okay when he wasn't drinking. He was trying to use his shoulder on the doorway to stop the police from taking him away. Mr. Rupert's personality seemed to change when he was drinking. Ms Sinclair told me she was afraid of him and was afraid for her own safety when Mr. Rupert was drinking or taking pills.

He paid rent to Elaine Protano "Plus there was a caretaker all right, but he only showed up when something needs to be done." No one ever worked on the stairs where the vinyl runner was from the time he moved in until this accident. "She was saying something like she was, she was going to get it fixed, but she never fixed it up." He complained that he felt the vinyl runner was unsafe. "Every time I walk in here - - when it was raining my shoes were kind of slippery. So I had to hold onto those rails just to get up."

As to the way the police officer was holding onto Mr. Rupert, the police officer's hand was outside of Mr. Rupert's arm and not between Mr. Rupert's arm and his body.

<u>Witness No. 11.</u> Theresa Diane Sinclair testifying 8th day of October 2008. (Pages 75-118 of the transcript for October 8, 2008.)

(Examined by Mr. Peterson)

Theresa Sinclair had a relationship with Mr. Rupert for over a year at the time of this incident. They had separated for periods of time and got back together. On the 7th of June 2004 she and Mr. Rupert weren't together or had recently split up for a period of time - - when he went out and got drunk or intoxicated. She called Alan Rupert "Sonny". He and another guy "were on my roof . . . It was raining and it was dark. . . . I just told him to come back later and go away. . . I just didn't want to see him intoxicated." She was concerned with him being up on the roof when she thought he might be intoxicated. Somebody phoned the cops. She was trying to tell Sonny to get down from the roof as the cops were coming but he wouldn't go. "And then he told me, he said, I'm just going to sit here and wait for them. In regard to the window, "A friend of mine put screws in the window for me. . . . Because I didn't want nobody climbing through my window." When Sonny was brought out "He had no shoes on. . . ."He had shoes on when he was on the roof." When she went down to see where Sonny was after being led by the

police she "looked at the bottom of the stairs and he was laying there . . . on his stomach." She was terrified. She saw Sonny on the ground being attended to by some paramedics. After the paramedics took Sonny away, "there was a woman cop that came back to my place. . . . It was rainy." When Sonny was out on the roof and she was talking to him he was intoxicated. When they brought Sonny out of Ms Sinclair's room he was not handcuffed.

(Examined by Mr. Pollock)

The handrail was in proper working order. When she went up and down the stairs after coming in from the rain down that that vinyl stairway she did slip herself because of moisture. The vinyl "was something like plastic, but it - - wasn't nailed to the floor and that vinyl kept slipping. . . it wasn't safe. . . . I was going down the stairs one day and I almost slipped down there, but it would - - like going down I almost slipped." When Sonny took pills and drank, he never got white froth around his mouth that she saw. She had never seen Sonny slip on the stairs going up or down even when he was in an intoxicated condition.

(Examined by Ms Carswell)

On the Thursday before the incident, Ms Sinclair had her windows screwed shut. "I was only protecting myself to be safe." In Ms Sinclair's statement to police she said, "On Thursday when I broke up with him, he said he was going to shoot my kneecaps off. He said, I'll make sure you never walk again. On Friday he told me that he was going to get his family to come here to beat me up. . . . I was afraid of his family. . . .I didn't provide the runners to the cops. They came and got them."

(Examined by Mr. McDonald)

Ms Sinclair moved into the building initially in the year 2000 when the owner of the building was Ron Yuppie and Social Assistance paid rent on her behalf to him. When she was first there for the two year period, there was a plastic runner on the stairs then. It was never replaced from the time she moved in until she left the first time. She moved into the building for the second time in 2004 and was in that building for about three months before Mr. Rupert's accident. The same vinyl runner was on the stairs. At that time the rent was paid to Manchester Properties. She felt that the plastic runner on

the stairs was hazardous and unsafe, even more so if it was wet because it got slipperier.

<u>Witness No. 12.</u> Cameron Peterson testifying 9th day of October 2008. (Pages 1-20 of the transcript for October 9, 2008.)

(Examined by Mr. Peterson)

Cameron Peterson is a medical doctor employed at the Health Sciences Centre in Winnipeg. He graduated from medical school in 1992 and has been at the Health Sciences Centre since July 1, 1995. He has worked in the emergency room since July 1, 1995, for 13 years.

In his position he would spend a short amount of time with a particular patient coming in. Once it is determined what treatment is needed, the patient is moved on to another area.

Back on the 7th of June 2004 he was working in the emergency room at the Health Sciences Centre when he saw Alan Rupert at about 1:00 a.m. when he was brought in by the paramedics, after he apparently fell down some stairs and wasn't moving after that. On examination initially he had a decreased level of consciousness, had some slurred speech, and was not moving except a little bit in his left arm. His blood pressure was low and suspicion was that he may have a cervical spine injury. X-rays of his neck, chest and pelvis were ordered. The decrease in the rectal tone was suggestive of spinal cord injury. "My preliminary interpretation of the x-ray was it looked like he had a fractured rib on the left. . . . And there was some soft tissue swelling opposite his second cervical vertebrae . . . which were a little suspicious. . . . I ordered a, a CT scan of his spine." It was determined that, in fact, he did have a broken neck and not necessarily a broken neck but a spinal cord injury. "I have documented here the ethanol level was 43. . . . an ethanol level of 17 would correspond roughly to .08, so this would be a little over two times the legal limit. . . . from one to six he's technically under my care." He was admitted to the Surgical Intensive Care Unit at 6:00.

It is not possible for someone out on the street such as a police officer seeing someone lying in a prone position, making a diagnosis just on viewing the person. Paramedics trained in C-spine immobilization always take precautions in that case by stabilizing the neck with a C-collar. There is

potential danger that movement may aggravate the injury and a collar is put on to immobilize.

(Examination by Ms Carswell)

But further movement also may not aggravate the injury dependent on the movement.

On pages 13 and 14 of the transcript the doctor detailed drugs indicated by the bottles that were seized from Mr. Rupert. At the time the x-ray of Mr. Rupert was taken at 10:25 a.m. no aspiration pneumonia was indicated but an x-ray about half a day later does show some indications of aspiration pneumonia.

"Usually what happens with an aspiration pneumonia, what happens is some will - - when you aspirate basically you have contents from your mouth or stomach that go into your lung. That's called an aspiration. Usually you don't get an aspiration pneumonia right away. You have to aspirate the stuff, it has to be there for awhile and then you develop a pneumonia. Lots of people will aspirate and they don't develop a pneumonia. . . . You don't necessarily treat them until they develop symptoms suggestive of a pneumonia." The relationship between quadriplegia and aspiration pneumonia is extremely common because it can be related to position. If the person is lying down a lot and not upright, that person is not necessarily clearing their lungs like a normal person can and they are just more prone to aspirating because of those reasons.

<u>Witness No. 13.</u> Thambirajah Balachandra testifying the 10th day of October 2008. (Pages 1-47 of the transcript for October 10, 2008.)

(Examination by Mr. Peterson)

He is the Chief Medical Examiner for the Province of Manitoba since 1999 and as such involved himself in the case of Alan Earle Rupert. He was contacted by a member of the Winnipeg Police Service regarding the death of Mr. Alan Rupert and then learned that the death was not reported to his office. Investigation indicated that this person was admitted to the Health Sciences Centre on June 7th, 2004 at 0100 following some incidents with the Winnipeg Police. "And from that time onwards he was in the hospital and ultimately he died on February 13th, 2005.

The body was released from the hospital and taken to the funeral home and was embalmed by the funeral home. The funeral was to take place the following date. He decided to go through the cause of death given by the police station and reviewed the history and agreed with the physician as to what he said. He made the decision not to do a full autopsy but to do an external examination because Mr. Rupert was in the hospital for many months, was "cared for by the best hospital possible in Manitoba", it was not a sudden death, it was an expected death and the physician disclosed the cause of death. Also because doing an autopsy on an embalmed body is difficult because it is full of all kind of chemicals and because of the concern for the family that wanted the planned funeral to take place the following day. A full autopsy "may have provided information which may not be useful for me to arrive at the cause and manner of death." The immediate cause of death was aspiration pneumonia "which he had been having since the fall many times and ultimately . . . the caring physician opined that it was aspiration pneumonia and I agreed with it." The aspiration pneumonia is due to or a consequence of quadriplegia due to a fractured cervical spine which was due to his fall. Pneumonia is common in quadriplegics "because the chest wall muscles are not working, because they're paralyzed. . . . And so they can't have an effective cough to clear the secretions. . . . So that will cause an accumulation of secretions and infections. . . . That's one of the complications of quadriplegia." Looking at the history of the case Dr. Balachandra was satisfied that quadriplegia was suffered as a result of the fall because, "this person was found on the roof of a house and nobody put him there, he got on his own to the roof." This would indicate that he was quite agile to get onto the roof on his own, that he went into the upstairs through a window and "Then apparently coming down he had a fall - - landed on the landing and soon afterwards he found, the police officers found that he could not move and he was a different person, then they call the ambulance. So my opinion was that all his problem was because of the fall." And pneumonia is one of the consequences of the fall and breaking of his spine. The autopsy would not have changed his opinion in this particular case.

(Examined by Mr. Pollock)

While it can not be said that Mr. Rupert was a complete quadriplegic after he fell down the stairs because he had some movement in his left arm but for all intents and purposes he was a quadriplegic. "Once you have total damage to some part of the nervous system it doesn't work right away. . .

Immediately after the fall. If there was total damage to the cervical or cervical spine or cord, then he would have been completely paralyzed from that time onwards." Mr. Rupert would not be capable of bearing weight on his legs. "Had I been at the incident when this happened, I would have asked him how is he doing, how are you doing, sir. I would have asked the question to the fallen man and saying are you okay." And if Mr. Rupert is responding with "Aw fuck" then Dr. Balachandra indicated, "You ask two or three times and then he will sober up and answer the question whether he's okay or not. . . . But if a man was intoxicated, had fallen down the stairs, perhaps had I been there I would have removed the handcuffs and then asked him how he was doing depending on the circumstances." Somebody who suffers, who is suspected of suffering a cervical injury should not be moved. The thing a medical person would want to know is whether or not the person had any feelings in his legs and some of the questions they would ask are if the person can move, can they feel anything in their feet, can they move their legs? The reason they do that is because you want to assess their neurological function capabilities. As to whether there would always be absence of feeling in the legs shortly after the fall, "Not always. If the spine is broken or some type of movement and if it did not affect the spinal cord, maybe he'd be okay, but the problem is then you start moving around later, then he may get injury." So that possibly his injury may have been incomplete after the fall but once they moved him it may have become complete.

There are two possibilities that either he was rendered a complete quadriplegic after the fall, or he was rendered a quadriplegic after they moved him. "He has some movement of his left upper limb, therefore he could operate, maybe he could operate some years, not fully was able to move his left upper limb but he could have manipulated the left." Some therapy is called for in a situation such as this in order to improve the movement of the upper body, including the one arm that had some mobility and perhaps develop mobility in the other arm but "First of all, they immobilize him to give rest to the cervical spine so that there's no further injury and there's no movement so that it will start healing and you hope for the best and there's a lot research going on with the spinal cord. . . " Mr. Rupert's injuries stabilized before he died, that would allow for a reasonable application of some therapy which would obviously improve his circulation. And "he was moved from the general hospital to the rehabilitation hospital for rehabilitation, but obviously it did not work. Because you have a lot of interplay between the person's ability and his willingness to cooperate and fight the disease and come out of it, plus the amount of treatment that was

given to him, support services, given all those things, so there was a lot of, there are a lot of factors involved in the total outcome.

He was not a complete quadriplegic, “that’s why he was able to move his arm, left arm, so it was partial. . . . But in addition I should also inform the courts that he had some spinal disease before, some spinal stenosis and all those problems, so he was not a fit young, athletic man who all of a sudden build up this because of this fall.”

From the summary Mr. Pollock reads, “It says on his visit to the clinic on March 24, 2003, he has right L4 to S1 radiculitis and was not able to return to gainful employment because of pain, reduced movement to the spine, persistent radiculitis and reduced functional capabilities. He had very limited sitting and standing tolerance. Dr. Balachandra said, “had he been a normal built adult male, first of all would not have fallen down the stairs, even if a normal person, very athletic had fallen down, he might have not sustained this much of injury. Probably this man had a problem with his spine to begin with that contributed to his injuries. Plus it was noted by the officers and also at the hospital that he was intoxicated, so that also could have contributed to his fall and sustaining this kind of injury. A normal person falling would sustain less injuries compared to a person who is intoxicated.”

(Examined by Mr. McDonald)

The late Mr. Rupert had pre-existing spinal problems. A normal person would not have suffered the same degree of injury as a result of that fall as Mr. Rupert did because Mr. Rupert had pre-existing problems, that is “If two people, one normal athletic person . . . not intoxicated, no spinal problems, had a fall exactly like this . . . the outcome would have been quite different.” . . . “the outcome would have been different. I can’t say how the degree of severity of injuries.”

(Examined by Ms Carswell)

When asked if he would support a recommendation that in cases where a person has been seriously injured as a result of contact with the police or in contact with the police, that samples taken, such as blood samples, be maintained until they’re released perhaps by his office so that these kind of tests could be done?, Dr. Balachandra responded, “I totally support but also want in other cases to be included, for mostly homicides or the patients come

with a stab injury and we want to be involved right from there so that can . . . so that the act allows us to get involved, but we, the act does not . . . force the hospitals to inform us. Why if they inform us we could have immediately got involved but I suppose that act has to be changed to make it mandatory for the physicians to inform our office if there is a more than likelihood of a person dying and it will become ultimately reportable. As in this case, it was definitely reportable, so there's a very high chance that he could have died and therefore the hospital, the onus should be on the hospital administration to inform our office." Dr. Balachandra agreed there should be a system where his office would be informed where it's a reportable incident and where there is a serious injury with a likelihood of death.

It was the police service who ultimately notified Dr. Balachandra's office that Mr. Rupert had been deceased so that they could become involved in the case. Ms Carswell, "There are things obviously, therapy that could be done with respect to the adverse effects of quadriplegia, suctioning of the lungs and all of those types of therapies would be something that the patient would have to consent to", a patient could refuse that therapy and that would adversely affect them. A quadriplegic can refuse to have his lungs suctioned and that would then have an adverse effect on his longevity. If that person allows a physician to turn him in bed or staff to turn him over as a quadriplegic, that likely would adversely affect longevity and also cause bedsores. If that person refused to be put upright, sit up and have physical therapy, that would adversely affect longevity.

<u>Witness No. 14.</u> Ronald Bilton testifying the 10th day of October 2008. (Pages 50-102 of the transcript for October 10, 2008.)

(Examination by Mr. Peterson)

This witness is a sergeant with the Winnipeg Police Service in his 21st year. His curriculum vitae is Exhibit 3 which included a position at the Training Division where he "was responsible for training officers in all aspects of officer safety, all aspects of use of force. That would include any weapons with the exception of firearms because we have a specific firearms unit." In the circumstances surrounding Mr. Rupert at that time it was appropriate to handcuff him where there is a suspected criminal offence and some indication of impairment and some degree of struggling with the police. (Page 53) "It would be for two reasons: for the officers' safety and for the subject's safety as well to prevent a person from using his hands or ultimately

pulling out a weapon, especially a person that has already demonstrated an ability or desire to resist the officers." Standard policy indicates that you handcuff people with the hands behind their back, with certain exceptions.

As to the training and dealing with escorting a person up and down stairs or narrow stairs, (page 55) "There's nothing written in any policy or any manual discussing that exact topic" but during his training division experience with recruits questions surrounding the staircase use come up and are discussed. In this particular case one appropriate procedure in escorting an arrested person down the staircase would have one officer walk in front of the suspect down the stairs followed by the suspect and the second officer behind him. (Pages 56 & 57) This is so, provided that the officer is beyond the reactionary gap, a distance of about six feet, and thereby placing his head beyond a position where he could be kicked, the officer optimally should "descend to the bottom of the stairs, put himself in a position so that he could be prepared for the subject's descent and basically accept that person as they were coming down the stairs. So he would be facing the subject."

The second "alternative would be to have the secondary officer behind the officer who is escorting the prisoner down the stairs. One officer should have his hand on the subject's arm" which opens up the opportunity for escape. As to the grip on the suspect recommended would be underneath and grabbing the triceps area and specifically the hand of the officer should be between the person's arm and their body and definitely not with the hand on the outside of the person's body "simply because of the position of your hand. Your hand is not going to have as much strength upside down this way . . . Your grip strength would definitely probably be stronger in this, in this matter." There is no way you can train someone specifically from slipping and falling.

In conclusion in his report Sergeant Bilton believes that the use of force was appropriate and reasonable under the circumstances and nothing inappropriate in the manner of escorting Mr. Rupert down the stairs by the one officer. It is safe to say that you can not be trained for every possible scenario and every eventuality.

(Examination by Pollock)

Taking a person down the stairs in a safe manner may include using dialogue with the person escorted. Dialogue constitutes 95% of police work.

The importance of dialogue is so that you're communicating actively with the prisoner. Mr. Pollock said, "So what you tell your students is that you have to make sure that when you escort somebody down a steep stairwell who's handcuffed behind his back and who is intoxicated, that you do so as safely as possible, correct?" Sergeant Bilton replied "Yes." Mr. Pollock, "And if there is a handrail to use for the officer to balance himself, that he should use the handrail because it's there to stabilize in walking down the stairwell, correct?" Answer, "Well, if he had an opportunity to use it, yes."

The escorting officer in using the handrail would not significantly impede his access to his hand firearm for his own safety because his hand would not be anchored with a voluntary clasping of the handrail and he could move his hand as quickly from the handrail to his weapon as if it was apart from the handrail.

As to Constable Pedersen removing the handcuffs and then allowing Mr. Rupert to descend the stairs using the handrail without the cuffs and Constable Pedersen could have gone down the stairs and then at the bottom of the stairs Rupert could have been cuffed again, hands behind his back, and escorted to the cruiser car, as to that being an available option, "It was an option but the officers decided not to do that because they had already dealt with a person who was not following their instructions from the get-go, from the time they had requested he get off that roof he wasn't following their directions. Up until the time that they told him to get on his stomach on that roof, he also didn't follow their instructions, he also proceeded through the window. He had something in this hand. The officers didn't know what it was. They asked him to drop it, he didn't drop it. Therefore I think it's safe to say that the officers assumed that there was a high potential for this person to resist. If there's a high potential for a person to resist and he's intoxicated, it would be irresponsible of the officer not to cuff the individual and especially irresponsible to cuff the individual in front. . . . So he should be cuffing that person and it should be with his hands behind his back." He should exercise great care in taking him down the stairs.

Mr. Pollock asked, "Well then what is the training that you were given to determine whether or not somebody has a spinal injury other than asking them if they're okay? Sergeant Bilton, "I mean it's basic first aid for, for police officers. The only other information that an officer might know is don't move the person. If you suspect that they have a neck injury, then don't

move the person and wait till someone that's qualified to move the person gets there to move the person."

<u>Witness No. 15.</u> David William Easton testifying the 10th day of October 2008. (Pages 102-118 of the transcript for October 10, 2008.)

(Examination by Mr. Peterson)

Dr. Easton is a medical doctor graduated from training and medicine in 2002. He is currently employed at the Health Sciences Centre as an emergency physician at the Health Sciences Centre, specifically, plus is an intensive care unit doctor in the WRHA and attends in the different Intensive Care Units in the City including the Health Sciences Centre.

He had occasion over the approximately eight or nine months he was in hospital to treat Mr. Rupert and was his treating physician during the last few days of his life. "Mr. Rupert was a 46-year-old gentleman from Winnipeg and he was admitted back in June after a fall down stairs and this had resulted in a cervical spine fracture that left him quadriplegic and during his course after that, he had a very long, complicated hospital stay and as these patients often get, he ran into numerous respiratory difficulties."

"One of the things you run into with quadriplegia is you can have respiratory muscle weakness and mainly what that leads to is poor coughing, poor, what we call pulmonary reflexes and that often leads to retained secretions and just makes you more prone to getting chest infections and pneumonia." His respiratory difficulties were mostly related to the fact that he was a quadriplegic. ". . . subsequently he was transferred to the rehab hospital after his acute phase of his illness and there he again had further complication with recurrent aspiration and pneumonia. And I guess he had some difficulties on the ward with cooperating with some care and as it came to be, I'm just sort of, again, paraphrasing here also, he made it clear that, you, he had been through a lot and he did not want any more what I'm going to say is aggressive interventions, i.e. artificial ventilation, further tracheostomy which is the artificial windpipe you can put in your inner throat which is, I guess, what he had when he was first admitted to hospital."

"And when I got involved it was due to him having complications of pneumonia and he had just been getting progressively worse and worse and again we had numerous discussions with him about things that we had to offer

him and in the final analysis he did not want any further, again what I would suggest aggressive care, that again from my perspective as an ICU doctor I would be thinking of offering, i.e. mechanical ventilation and tracheostomy. We provided the care that we could, that he wanted and he did not approve and he subsequently died." The cause of death was aspiration pneumonia. "Aspiration pneumonia is a kind of pneumonia that can result from secretions going down the trachea. . . . secretions from, from your throat to your mouth or when you eat you might aspirate food, it goes down your windpipe" and it ends up in the lungs. Mr. Rupert made it very clear on numerous occasions that he did not want any intubation. "Intubation is an act of placing a plastic tube again through your mouth into your trachea or your windpipe into the lungs, with the express purpose of being artificially ventilated on a ventilator, so mechanic ventilation."

(Examination by Ms Carswell)

There were treatment options and treatments offered to Mr. Rupert where he refused to accept treatment, in particular, physiotherapy, turning, coughing, suction.

(Examination by Mr. Peterson)

With regards to the Notification of Death form to be completed by the physician or delegate on the box square as to whether the death is reportable to the Medical Examiner's Office under *The Fatal Inquiries Act* the box being checked off "no" was not checked off by Dr. Easton. "Again, that was not me checking that box on this particular piece of paper. This was presumably the same person that was, that was writing as above there, the designate."

This is SCHEDULE C and forming part of the Report of the Inquest by the presiding Provincial Judge in the Inquest of Allan Earle Rupert, setting out the applicable provisions of *The Fatality Inquiries Act*, the history of the inquest and an analysis of the evidence and the material circumstances surrounding the initial injury while in the custody of the police and eventual death.

WHEREAS s. 19(1) provides that upon receipt of an investigation report the Chief Medical Examiner shall review the report and determine whether an inquest ought to be held, the Chief Medical Examiner under s. 19(2) determined that an inquest ought to be held and by letter to Chief Judge Raymond Wyant dated the 4th day of May 2005 directed that a Provincial Judge hold an inquest, in these words:

> "Thus, in accordance with *section 19* of *The Fatality Inquiries Act*, I am directing that an inquest be held into the death of Alan Earle Rupert for the following reasons:
>
> 1) to fulfil the requirements for a mandatory inquest as defined in *subsection 19(3)(b)* of the Legislation;
> 2) to determine the circumstances under which Mr. Rupert's death occurred; and,
> 3) to determine what, if anything, can be done to prevent similar deaths from occurring in the future."

WHEREAS under s. 26(1) a direction is given by the Chief Medical Examiner under s. 19 that a Provincial Judge shall conduct an inquest Chief Judge Raymond Wyant assigned Provincial Judge Theodore Lismer to conduct the inquest.

H. Neil Peterson was named as inquest counsel.

The following practicing members of the Manitoba Bar under s. 28(1) were granted standing as persons substantially and directly interested in the

inquest, they attended the inquest on behalf of their respective clients and examined or cross-examined witnesses called at the inquest. They are:

Mr. Neil Peterson, Inquest Counsel
Mr. Robert McDonald, for the police officers
Ms Kimberly Carswell, for the Winnipeg Police Service
Mr. Martin Pollock, for the family
Mr. Sarantos Mattheos, for the Winnipeg Regional Health Authority
Mr. David Cordingley and
Mr. Ross McFadyen, for the property owner

Under s. 30(5) the evidence of the witnesses at the inquest was taken in accordance with the provisions of *The Summary Convictions Act* respecting the taking of evidence of witnesses and proceedings under that *Act*. Transcripts of the evidence were prepared and will be submitted with this report.

In compliance with s. 31(1) this inquest was open to the public.

The time-consuming compilation of all the records and documents requested by counsel and the availability of all counsel having standing to attend and participate initially expected to take up to two weeks delayed the commencement of the taking of evidence at the inquest. All the evidence was received in Courtroom 316 of the Law Courts Complex from the 6th to the 10th day of October, 2008, both inclusive, the last submission by counsel was received on the 14th day of November 2008, which then completed the inquest.

This written report and recommendations are made pursuant to s. 33(1) of the *Act* which provides:

> "After completion of an inquest, the presiding provincial judge shall
> (a) make and send a written report of the inquest to the minister setting forth when, where and by what means the deceased

> person died, the cause of death, the name of the deceased person, if known, and the material circumstances of the death;
> (b) upon the request of the minister, send to the minister the notes or transcript of the evidence taken at the inquest; and
> (c) send a copy of the report to the medical examiner who examined the body of the deceased person;
>
> and may recommend changes in the programs, policies or practices of the government and the relevant public agencies or institutions or in the laws of the province where the presiding provincial judge is of the opinion that such changes would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in the death that is the subject of the inquest."

Allan Earle Rupert died on the 13th of February, 2005 as a result of aspiration pneumonia due to quadriplegia due to a fractured cervical spine sustained in a fall down a narrow flight of stairs on the 7th day of June 2004 while in the custody of the Winnipeg Police Service. Save for the slip on the wet plastic stair covering, the escort of the deceased down the narrow flight of stairs from the second floor of 704 Magnus Avenue down to the cruiser car was anticipated to be routine. There is no suggestion that the police pushed or threw the deceased down the stairs but this accidental plummeting down the stairs was catastrophic for Mr. Rupert.

During the course of his eight month stay under hospital care at the Health Sciences Centre, Mr. Rupert declined recommended aggressive medical procedures including recommended diet and suctioning of his lungs to supplement his own ineffective coughs and his debilitated chest wall muscles to clear his lungs of his own secretions, his refusal to the turning over of his body to minimize bed

sores and refusal to take the prescribed medication contributed to his ultimate demise.

There are several versions in the evidence as to this accidental slip. Whether Mr. Rupert slipped causing the police officer escorting him to loosen his grip on Mr. Rupert and slip as well or whether the police officer slipped on his own causing him to lose his grip on Mr. Rupert or whether they both slipped simultaneously **does matter** in this inquest as to any recommendations that should be made as a result of this experience.

The narrow confines of the stairway even though equipped with a stable handrail posed a significant challenge to the police officers in escorting him down the stairs which were too narrow for two officers to walk beside Mr. Rupert abreast. The police officers negotiated the same flight of stairs when initially they ascended to the second floor into proximity with Mr. Rupert who was then still on the roof of this private dwelling house. It was raining that night and the runner may have been wet then and likely slippery. Mr. Rupert had his shoes on when he was on the roof but he was escorted down the stairs unshod except for stockings. The attention of the police officers apparently not focused on his footwear and could give no explanation as to why or when his shoes were removed. Common sense suggests that stocking feet with no tread provide less traction especially on wet surfaces than treaded footwear and more prone to kneejerk reaction to any irregular floor or stairway surface in this old private dwelling house. There was no evidence from a thorough inspection of the condition of the vinyl covering and carpet that the surface of the stair at the point of slippage was free of any sharp or irregular protrusion that may have interfered

with the regular step-by-step movement down the stairs and contributed to the slip.

From the evidence it is clear that the loose vinyl covered stairway aggravated the danger or risk especially when wet on the night of the fall. It would appear that the hazardous condition of the stairway contributed to the cause of the fall.

According to Sergeant Bilton the force used and escort process followed by Officers Pedersen and Freeman was appropriate; was in accordance with proper procedure; and Rupert was escorted down the stairs in a safe manner. Nevertheless, the experience of this accident points to certain basic recommendations to be implemented as to the safe escorting of an intoxicated, unsteady person handcuffed behind his back down a narrow and hazardous stairway. While Winnipeg Police Service may already provide regular mandatory training in both first aid and the use of force issues and while attempts to train for any and all scenarios that may be encountered by police is impossible, the experience here does point to certain accident prevention recommendations for future police interactions with persons in circumstances such as in the Rupert scenario.

This is SCHEDULE D, forming part of the Report of the Inquest setting out my recommendations.

1. I recommend that the regular mandatory training and procedure manuals distributed to each police officer should include that the mind should be focused on all variables that may have a bearing as to the safe conduct of the police officer in circumstances such as that in this inquest. The direction should include that the police officer in each case consider the use of dialogue in the escorting of a person in custody to promote unison with the escorting police officer and orienting his mind as to what is occurring at any given moment. Sergeant Bilton conceded that a running commentary would be useful in many situations.

2. That the police officer give due consideration to the proper and most effective grip on the escorted person's arm and the recognition that the looping of the officer's arm around and above the escorted person's elbow so that the officer's arm is between the arm and the body of the escorted person is an effective grip. In this case the officer appears to have had his grip on the outside of the arm of Mr. Rupert, which proved ineffective in holding on to Mr. Rupert after the slip.

3. Serious consideration by the police officer to the use of the handrail which was available to stabilize the escort in the

event of a slip. The officer in this case did not utilize the handrail for reasons as articulated in his evidence.

4. Consideration by the police officer to the footwear of the escorted person so as to provide him with the best traction available under the circumstances. In this case Mr. Rupert was escorted in his stocking feet, according to the best of the evidence. The officers themselves were unmindful of this and were unable to explain why and where Mr. Rupert's footwear was removed.

5. Consideration by each attending police officer to the positioning of the second officer, in this case Freeman, in front of the escorted person either at the bottom of the stairs or at a distance beyond the kicking range of the escorted person, so as to minimize the effects of any fall.

6. Consideration by the police officer to shackling the person's legs and reducing the kicking range of the escorted person, reducing the risk to the participating officer and reducing the risk of any attempted escape.

7. Every Winnipeg Police Service member in active duty should receive specialized first aid education and training sensitive to an accurate recognition of a potential spinal injury and that a person such as they found Mr. Rupert should not be moved before the arrival of appropriate emergency health care

personnel even where the fallen person was not complaining of any injuries but especially when scrapes to the side of the head were noted consistent with contact of the head with the door.

8. Direction to the involved police officer to ensure that in similar circumstances effective arrangements be made for blood samples to be taken and retained for the Chief Medical Examiner and to notify the Office of the Chief Medical Examiner of the serious injury sustained while in police custody. In this case the blood samples were taken from Mr. Rupert upon admission to the hospital but were not retained and were destroyed. This notification would enable the Chief Medical Examiner to consider the extent to the investigation to be conducted and the taking and retaining of blood samples.

9. That the policy of the Health Sciences Centre be amended as necessary to provide a reasonable notification to staff by cardex or chart cover or other effective means to alert all personnel involved of the requisite notification of the Chief Medical Examiner in the event of the death of a person in Mr. Rupert's circumstances.

10. In this case the Chief Medical Examiner, Dr. Balachandra, testified that he would have liked to have been informed by the Health Sciences Centre about Mr. Rupert's death before

his body was released to the funeral home and before it was embalmed in being readied for the funeral service the next day. In this case it was the police who informed the Chief Medical Examiner about this death. According to the evidence there is an established process followed by the Health Sciences Centre for reporting deaths to the Chief Medical Examiner which include requiring the physician who pronounces death to determine as to whether the death is reportable to the Chief Medical Examiner, whose decision is recorded on the Notification of Death form (Exhibit 8 – the death package). This is subsequently reviewed by the Admissions Office of the Health Sciences Centre which completes the checklist on the reverse side of the Notification of Death. The box in the checklist with a "No" as to his death being reportable but Dr. Easton who pronounced death testified that while he knew that Mr. Rupert sustained a serious injury while in the custody of police he is not the one who filled in that space with a "No". Dr. Balachandra characterized Mr. Rupert's case as an isolated incident which must have slipped through the cracks as a result of the passage of time between the accident and Mr. Rupert's death. I make the recommendation that the physician pronouncing death be instructed to effectively oversee the death package form such as Exhibit 8 to ensure that it is free of any misleading information especially as regards reportability to the Chief Medical Examiner.

DISTRIBUTION LIST

1. Dr. A. Thambirajah Balachandra, Chief Medical Examiner (2 copies)
2. Chief Judge Raymond E. Wyant, Provincial Court of Manitoba
3. The Honourable Dave Chomiak, Minister Responsible for *The Fatality Inquiries Act*.
4. Mr. Jeffrey Schnoor, Q.C., Deputy Minister of Justice & Deputy Attorney General
5. Director of Regional Prosecutions, c/o Ms Lisa Thierjer
6. Mr. Neil Peterson, Counsel to the Inquest
7. Mr. Robert McDonald, Counsel for the police officers
8. Ms Kimberly Carswell, Counsel for the Winnipeg Police Service
9. Mr. Martin Pollock, Counsel for the family
10. Mr. Sarantos Mattheos, Counsel for Winnipeg Regional Health Authority
11. Mr. David Cordingley, Counsel for the property owner
12. Mr. Ross McFadyen, Counsel for the property owner
13. Ms Aimee Fortier, Executive Assistant and Media Relations, Provincial Court
14. Mr. Michael Anthony, Exhibit Control Officer, Provincial Court