RELEASE DATE: April 29, 2020

Manitoba

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: *The Fatality Inquiries Act* C.C.S.M. c. F52

AND IN THE MATTER OF: Russell Andrew Spence, Deceased

Report on Inquest and Recommendations of
Judge Brent Stewart
Issued this 24th day of April, 2020

APPEARANCES:

Mark Lafreniere and Bryton Moen, Inquest Counsel
Kimberly Carswell, Counsel for the Winnipeg Police Service
Sean Boyd and Jim Koch, Counsel for Custody Corrections, Community Safety Division, Manitoba

Manitoba

THE FATALITY INQUIRIES ACT
REPORTED BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: RUSSELL ANDREW SPENCE

Having held an inquest respecting the said death on January 13-21, 2020, at the City of Winnipeg in Manitoba, I report as follows:

The name of the deceased is: Russell Andrew Spence.

The deceased came to his death on the 12th day of October, 2016 at the City of Winnipeg, in the Province of Manitoba.

The deceased came to his death by the following means: In the early morning of October 12, 2016, Russell Spence was arrested by Winnipeg Police and taken to the Remand Centre. He became involved in a physical struggle with guards during a strip search, which began at 0443 hours. The struggle continued for several minutes, during which Mr. Spence was reportedly struck in the torso multiple times with a closed fist. He was eventually subdued by guards with the assistance of Winnipeg Police Service officers and had a "spit sock" placed over his head. At 0447 hours, four minutes after the struggle began, he suddenly became unresponsive. Resuscitation efforts at the scene and at Health Sciences Centre were unsuccessful.

I hereby make the recommendations as set out in the attached report.

Attached hereto and forming part of my report is a list of exhibits required to be filed by me.

Dated at the City of Winnipeg, in Manitoba, this 24th day of April, 2020.

"Original signed by:"
Judge Brent Stewart

Copies to:

1. Dr. John Younes, Chief Medical Examiner (2 copies)
2. Chief Judge Margaret Wiebe, Provincial Court of Manitoba
3. The Honourable Cliff Cullen, Minister Responsible for *The Fatality Inquiries Act.*
4. Mr. Dave Wright, Deputy Minister of Justice & Deputy Attorney General
5. Mr. Michael Mahon, Assistant Deputy Attorney General
6. Mr. Mark Lafreniere, Counsel to the Inquest
7. Mr. Bryton Moen, Counsel to the Inquest
8. Ms. Kimberly Carswell, Counsel for the Winnipeg Police Service
9. Mr. Sean Boyd, Counsel for Custody Corrections, Community Safety Division, Manitoba
10. Mr. Jim Koch, Counsel for Custody Corrections, Community Safety Division, Manitoba
11. Exhibit Coordinator, Provincial Court
12. Ms. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court

I. MANDATE OF THIS INQUEST:

[1] By letter dated November 8, 2017 the Chief Medical Examiner for the Province of Manitoba, Dr. John Younes, directed that a Provincial Court judge conduct an inquest into the death of Russell Andrew Spence for the following reasons:

> 1. To fulfill the requirement for an inquest as defined in Section 19(3)(b) of *The Fatality Inquiries Act*;
>
> 2. To determine the circumstances relating to Mr. Spence's death; and
>
> 3. To determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[2] By virtue of s. 33(1), *The Fatality Inquiries Act* requires that the presiding provincial judge:

> (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 the 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.

[3] The inquest commenced with notice to the public that a Standing Hearing would be held on June 18, 2018. Standing in this inquest was granted to the Winnipeg Police Service and Corrections Manitoba. The inquest heard evidence and submissions on January 13-23, 2020.

II. INTRODUCTION:

[4] The Office of the Chief Medical Examiner has called an inquest into the death of Mr. Russell Andrew Spence, aged 31 years, who was pronounced dead on October 12, 2016 at the Health Sciences Centre in Winnipeg.

[5] It was at the Winnipeg Remand Centre during intake that Mr. Spence was involved in a physical struggle with guards during a strip search, and ultimately became unresponsive. Thereafter, he was rushed to the Health Sciences Centre where he was determined to have passed away. As a result of Mr. Spence being in custody at the Winnipeg Remand Centre at the time of his death, in accordance with the *Fatality Inquiries Act* an inquest was called, which is mandatory under the circumstances. The Chief Medical Examiner has asked that this Court determine the circumstances relating to Mr. Spence's death and also to determine what, if anything, can be done to prevent similar deaths from occurring in the future.

[6] This inquest was ably conducted by Inquest Counsel, Mr. Mark Lafreniere, with the assistance of Mr. Bryton Moen. Their organization as it relates to the exhibits and witness preparation allowed the hearing to proceed in a clear and forthright manner. The other counsel who joined in this inquest was Ms. Kimberly Carswell, who represented the Winnipeg Police Service and Mr. Sean Boyd and Mr. Jim Koch, who acted on behalf of Corrections.

[7] The family of Russell Spence chose not to have counsel appear on their behalf, however mother and aunt, along with siblings, did attend throughout the entire inquest hearing and ultimately made representations at its end.

[8] Twelve witnesses were heard throughout the course of the inquest.

III. SUMMARY:

[9] It must be said that this inquest has had the benefit of video surveillance throughout almost all of the events that occurred, unfortunately, with the exception of the shower room where the death occurred.

[10] The first two witnesses that the inquest heard were Winnipeg Police Constables Hart and Corriveau, who were dispatched to the 7-Eleven store on Ellice Avenue at 11:23 pm for a check well-being call. It was determined that a male entered the store. The man approached the cashier and put a knife and a pair of scissors on the counter and asked the clerk to call the police for him. He also

indicated that he was there to hurt no one and simply wanted help. The inquest reviewed the video footage from the store and it reflected exactly that. For the almost 10 minutes it took for the police to arrive Mr. Spence, although restless, had his hands up and upon the arrival of the officers immediately dropped to his knees and put his hands behind his back. The constables immediately cuffed Mr. Spence without any discussion and removed him to the police vehicle. Clearly this was not a check well-being call viewing the conduct of the officers. At the police car, upon the computer search of Mr. Spence's record etc., an unendorsed warrant came to light for his failure to attend police identification. Because Mr. Spence came to the store and left a knife and scissors on the counter, he was charged with possess weapon x2. Thereafter he was transported to the Winnipeg Police Headquarters.

[11] Upon the initial arrest Mr. Spence was cooperative and polite. Upon review of that arrest, the constables could only point out that he was sweating profusely and he made a strange utterance that he was not a skinner (pedophile). He also said to the clerk that he was being chased, however, the clerk saw no signs of this during the 10 to 15 minute stay. He was taken to Headquarters where an initial search occurred in the loading dock area (sally port) and the log sheet was filled in. At some point during this arrest Mr. Spence indicated that he had consumed methamphetamine (meth) and alcohol earlier that day. Again, both officers describe him as exhibiting no signs of intoxication. At the police station a prisoner log sheet was filled out prior to the prisoner being taken to the Central Processing Unit (CPU). This reflected as a result of his self-declaration of consumption of a drug and alcohol that he was impaired. It also recommended that a psychiatric assessment be completed prior to his arrest, apparently as a result of his bizarre behaviour.

[12] Upon being taken before Sergeant Glover, the reviewing Sergeant at CPU, he was asked several questions to which he politely replied. At one stage however, he suddenly stated he was not a skinner which came out of the blue. In her report, Sergeant Glover also stated that upon Spence being transported to the Remand Centre that he dropped to his knees in front of her and did not move. She described him as looking angry and clenching his hands together. He was helped up by a cadet and entered the transport vehicle. No inquiry was conducted into this by the Sergeant.

[13] Patrol Sergeant Woods, a 30-year veteran, was the supervisor in CPU that dealt with Mr. Spence after he was initially viewed by Sergeant Glover. Spence was

placed in a holding room and given his opportunity to phone counsel, which he did. According to procedure he was checked every 15 minutes for his well-being and ultimately transported at 4:15 a.m. Sergeant Woods decided to transport three prisoners to the Remand Centre along with Constable Phan. In his opinion, the transport was unremarkable and the only occurrence which stands out is the chanting of one of the prisoners during the trip. Sergeant Woods did not bother to determine who was causing this disturbance or why. At the Remand Centre, the three prisoners, a female and two males, were taken to the admissions desk at the Remand Centre where the female was processed first and the two males were placed in a side room to wait. Mr. Spence then went to the admissions desk where he was searched by Constable Phan followed by a second search by a Winnipeg Remand staff officer. Custody of Mr. Spence was then turned over to the Remand staff with no mention of strange behaviour of Mr. Spence.

[14] We then had testimony from Constable Phan. Constable Phan was with the CPU and was responsible for arranging for Mr. Spence to attend identification and ultimately to be a guard when Mr. Spence was transported to Remand. During the identification process Constable Phan noted two bizarre statements from Spence saying "I didn't rape that little girl" and "I'm not a rapist". As well, he testified during transport Mr. Spence appeared to be chanting, singing or hollering indiscernible words. All of these abnormalities were not communicated to the corrections officers upon the transfer process. I suspect from the evidence received that since the prisoner was cooperative and not acting out such a report was unnecessary in the police constable's view.

[15] Mr. Spence's custody was transferred to the Remand staff and after a cursory search his photo was taken and some questions asked with limited answers given.

[16] Corrections Officers Starkell, Gagic and Lavoie directed Mr. Spence to go into the shower/search room. Prior to this, Officer Gagic reported that Mr. Spence began making bizarre statements such as "Fuck you guys I'm not a skinner", "I don't care what you think, I didn't rape that little girl". At the admissions desk he stated "I forgive you guys, just beat me already". Again, despite these comments, no concern was shown by the officers that the remarks might reflect an imminent outburst. Officer Starkell did, out of an abundance of caution, ask for a third officer to accompany Officer Lavoie and himself. It must be noted that at this stage no thought of calling for the on duty nurse to do an assessment happened. Upon

entering the shower room Mr. Spence removed his clothing and threw them at Officer Lavoie. He then proceeded to charge at Officer Lavoie with clenched fists. Officer Gagic intervened and knocked Mr. Spence to the floor in a prone position. A scuffle took place with the officers trying to get control of Mr. Spence and handcuff him. Mr. Spence, being a big individual, kept his arms under his body to avoid those handcuffs and the officers clearly had difficulty to control him. Officer Starkell struck Mr. Spence a number of times in the right shoulder with a closed fist in an attempt to gain pain compliance while Officer Lavoie pressed his thumb behind the inmate's ear applying pressure. Both of these procedures are Corrections approved pain compliance techniques. As the skirmish continued more officers were drawn into the shower room including Sergeant Woods. Sergeant Woods grabbed Mr. Spence's leg and with the help of others had leg irons placed on him. A spit mask was also applied as he was spitting at the officers. It is important to note that throughout the skirmish at least one officer was on top of Mr. Spence's upper back/heart region.

[17] As the officers were in the process of getting Mr. Spence under control, he suddenly stopped moving and became unresponsive. Officer Starkell describes heavy breathing from Mr. Spence and then a complete lack of response. Mr. Spence was placed into a recovery position and a code red was called. Nurse Kroft arrived and was unable to get a response. Chest compressions were begun and an O_2 bottle and mask was applied. It appears that the AED machine was faulty and a second were used. Soon thereafter, emergency services paramedics arrived and took over the scene from Nurse Kroft. Mr. Spence was transported to the Health Sciences Centre where he was declared deceased.

[18] The inquest then heard from Dr. Raymond Rivera, the pathologist who completed the autopsy on Mr. Spence. A complete internal and external physical examination was done and thereafter tissue samples were sent for a toxicology assessment. The results of that forensic analysis determined that there was no alcohol in Mr. Spence's blood but there was a high level of methamphetamine in the blood being 1,343 ng/ml (I note this was long after Mr. Spence was placed into custody and would not have an opportunity to consume more methamphetamine from his arrest onward). The toxicology report concluded that this level may be associated with recent high dose methamphetamine use and as such toxic affects would be expected. It was Dr. Rivera's opinion that Mr. Spence died as a result of

a fatal heart rhythm (i.e. cardiac arrhythmia) that was potentiated by the toxic effects of methamphetamine in his blood stream. He also suffered from a slightly enlarged heart (borderline cardiomegaly) which would have increased his risk for developing cardiac arrhythmia. Lastly, being involved in a physical altercation would have had detrimental effects on the regular function of his heart and predisposed him to dying suddenly.

[19] The testimony received by the inquest culminated with the expert testimony of Dr. Gary Glavin who is an international expert in pharmacology. He is currently Associate Vice President (Research) and Professor, Department of Pharmacology and Therapeutics and Community Health Services, Max Rady College of Medicine, University of Manitoba. Filed as an exhibit is Dr. Glavin's report on the makeup and effects of methamphetamine (meth) in general and in specific to the Spence case. I refer to it extensively in the following text. This is a report that should be read by all involved with the criminal justice system which has exponentially become embroiled with the use of methamphetamine in criminal activities, especially in Manitoba.

[20] As to the general background of methamphetamine use, Dr. Glavin indicated that methamphetamine is either injected or smoked which gives an intense euphoria or rush. It is a cheap street drug which can go as little as $10 a hit. For a dose of methamphetamine to completely clear from a person's body, if no further drug is ingested, amounts to 60 hours. However, because of the high intense rush from the use of the drug, which can last up to 24 hours in duration, multiple dosing is frequently observed. Methamphetamine is sympathomimetic which means it stimulates a sympathetic nervous system response. This system is active in times of stress i.e. a fight or flight response in relation to psychological (fear or anxiety) or physical exertion or in the presence of physical danger. With methamphetamine the response is simply drug induced without cause. Symptoms of a methamphetamine user include elevated heart rate, elevated blood pressure, pupil dilation, increased body temperature, feelings of power and control, euphoria and sense of well-being.

[21] Dr. Glavin emphasised that with methamphetamine use there is an extreme load placed on the cardiovascular system. Depending on the dose the cardiac load can increase by 300 to 400%. The key to this hearing is the statement of Dr. Glavin that if there is an underlying or undiagnosed cardiovascular disease in the drug user,

it can easily be unmasked by this greatly increased load and lead to serious medical consequences including death.

[22] In addition to the cardiovascular risk, the acute stimulant effects are significant in the brain. Methamphetamine causes a massive release of dopamine which produces the pleasure stimulant. However, the side effect of this burst of dopamine is that it is a major cause of schizophrenia or psychotic illness.

[23] Long term methamphetamine use results in significant and permanent damage to the dopamine system in the brain. This can result in an amphetamine psychosis, long term depressive illness and long term permanent movement disorders.

[24] Dealing specifically with Mr. Spence, Dr. Glavin notes that his use of several medications becomes relevant to understanding the events leading up to his demise. Mr. Spence had been prescribed with an anti-psychotic medication. This drug is intended to reduce the dopamine production in the brain. As well, he was prescribed anti-depressant medications. These in general are used to increase the levels of either or both of the brain chemicals: noradrenaline or serotonin. Note is made in this report that many anti-psychotic drugs have been associated with increased risk of sudden cardiac death due to arrhythmia or irregular heart beat.

[25] In addition to the above prescriptions, Mr. Spence had a long term issue with hypertension and was prescribed several drugs for that problem.

[26] Upon the results of the autopsy being reviewed, Dr. Glavin notes that Mr. Spence was found to have an enlarged heart. This meant that the heart muscle was weakened and cannot contract and function normally. Secondly, it is noted that taking anti-psychotic medications can create arrhythmia. Finally, taking large doses of methamphetamine can induce cardiac damage, cardiomegaly and arrhythmia. In Dr. Glavin's opinion, all of these factors, combined with the stress of a physical struggle, pre-disposed Mr. Spence to a cardiac event and likely contributed to his death.

[27] My role in this inquest is to determine the cause of death and make any recommendations which may be followed to avoid a similar result in similar circumstances. These recommendations are based upon the evidence I have heard.

[28] In that regard, we must note that the reaction that individuals have as it relates to methamphetamine consumption is unpredictable. Unlike alcohol which exhibits

outward indicia to determine if an individual is intoxicated, unless there is a self-declaration, a methamphetamine user can hide his use of that drug on first glance. In our case, we do have an individual who called for police assistance and to whom, upon initial arrest, declared to have consumed methamphetamine and alcohol. The arresting officers through their arrest log noted this declaration and even made notation of mental health concerns. This concern was raised as a result of comments made by Mr. Spence reflecting paranoia (his being pursued), strange inappropriate comments (not a skinner) and his sweating profusely. After being transported to the Central Processing Unit however, no further follow up was made despite the repeated utterance he was not a skinner and later on his dropping to his knees when being taken to the Remand Centre. On the ride to Remand Centre the conduct of Mr. Spence chanting indiscernible utterances did not raise any concern. Finally, on arrival at the Remand desk when the hand over of the prisoner occurred, none of this behaviour was exchanged by the police to the Remand staff. The only notation of erratic behaviour was noted by the arresting officers in their written report which the Remand Centre would have received with all the other police documentation. However, the strange utterances continued while Mr. Spence was being processed by Remand staff. Still nothing was done to address this conduct except Officer Gagic asking for a third officer to accompany him into the search change room. It appears that all those who dealt with Mr. Spence viewed his comments as quirks and provided he was cooperative to their directions, all was good.

[29] Clearly the witnesses who testified reflected a complete lack of knowledge as to the effects and indicia of methamphetamine on individuals who they deal with such as Mr. Spence. As methamphetamine has become so prevalent on our streets this inquest recommends:

1) That mandatory methamphetamine training should be in place for all Winnipeg Police members and Correction Officers who deal with the arrest and processing of charged individuals who are in custody either at police headquarters or the Remand Centre. This training should educate these officers on the signs and symptoms of a prisoner who has consumed methamphetamine or other amphetamines. It should also include information on how to process such individuals while in custody including the force used to control such individuals.

2) The transfer of prisoners from the Winnipeg Police Central Processing Unit and the Remand Centre should ensure that all officers involved are made aware of the risk factors reflected in the prisoners log sheet. It is especially important that note is made of the prisoner's alleged use of street drugs prior to arrest and medical conditions which may require the handling of the prisoner in a manner different than the norm. Upon any such aberrations a nurse should review the accused prior to being lodged to determine if hospitalization is necessary.

3) The video units located in the CPU and Remand Centre should be upgraded to provide for a better quality of picture and audio to more clearly record all events of a prisoner's arrest.

[30] All of which is respectfully submitted.

I respectfully conclude and submit this Report on this 24th day of April, 2020, at the City of Winnipeg, in the Province of Manitoba.

"Original signed by:"
Judge Brent Stewart

Manitoba

THE FATALITY INQUIRIES ACT
REPORT BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: RUSSELL SPENCE

EXHIBIT LIST

Exhibit No.	Description
1	Black Inquest Evidence Binder 1
2	White Inquest Evidence Binder 2
3	Black Inquest Evidence Binder 3
4	Blue Inquest Evidence Binder 4
5	Spence Inquest Witness Schedule