CITATION: *R. v. Morden*, 2024 MBPC 62

THE PROVINCIAL COURT OF MANITOBA

BETWEEN

His Majesty the King	)	Jason Nicol and Vlatko Karadzic,
	)	for the Crown
- and -	)	
	)	
Robert Jeffery Morden	)	Richard Wolson (K.C.) and Daniel Wolson,
Accused	)	for the Accused
	)	
	)	Reasons for Decision
	)	Delivered: September 6, 2024

A. Cellitti, P.J.

1) Introduction

[1] The accused, Robert Morden, is charged with the following two offences:

> 1) ... on or about the 7th day of February, in the year 2021 at the Rural Municipality of Headingley, in the Province of Manitoba, did, while under a legal duty, fail without lawful excuse to provide the necessaries of life to William Ahmo, a person under his charge and unable, by reason of detention, illness or other cause, to withdraw himself from such charge and being unable to provide himself with the necessaries of life, thereby endangering the life of William Ahmo or causing his health to be injured permanently, contrary to Section 215(2)(b) of the *Criminal Code*; and
>
> 2) … on or about the 7th day of February, in the year 2021 at the Rural Municipality of Headingley, in the province of Manitoba, did by criminal negligence cause the death of William Ahmo, contrary to Section 220(b) of the *Criminal Code*.

[2] These are indictable proceedings. The accused entered not-guilty pleas to both offences, and the trial proceeded before me over the course of six days in September 2023.

[3] The alleged facts can be briefly stated.

[4] On February 7, 2021, the deceased, William Ahmo, was an inmate at the Headingley Correctional Centre ("HCC"). He was being housed on the Homer range. At approximately 12:30 p.m. on that day, Mr. Ahmo began to cause a commotion on the Homer range. He became very aggressive and belligerent. All of the other inmates housed in that range returned to their cells, leaving Mr. Ahmo alone in the common area of the range, which was locked. Mr. Ahmo began to damage various items within the range. It also appeared that Mr. Ahmo took possession of some items from around the range that could be used as or made into weapons. There were also periods of time where Mr. Ahmo was calmly sitting in the range. Video footage filed at trial showed that this occurred over the course of a few hours. A crisis negotiator was brought in to attempt to bring things to a peaceful conclusion. Those efforts were not successful.

[5] At some point, the Correctional Emergency Response Unit ("CERU") was brought in with a view to ending the stand-off. The CERU team was made up of correctional officers who volunteered and trained to be members. The accused,

Robert Morden, a correctional officer, was the captain of the CERU team that was brought in that day.

[6] The CERU team developed a plan that involved the use of force with a view to ending the stand-off. At approximately 3:45 p.m., the CERU team entered the Homer range. A confrontation ensued between Mr. Ahmo and the CERU team. Mr. Ahmo was combative upon the CERU team's entry into the Homer range and remained aggressive and resistant to the CERU team's efforts to subdue and restrain him. Mr. Ahmo was then removed from the range and brought into the rotunda, an area outside the range sometimes referred to as "the horseshoe" throughout this trial. Shortly after being removed from the Homer range, Mr. Ahmo was placed in an emergency restraint chair ("ERC"), a chair with wheels and restraints for a person's legs and arms. Mr. Ahmo was also seen by a nurse. During the course of the confrontation with the CERU team, Mr. Ahmo said on numerous occasions that he could not breathe. While in the rotunda, Mr. Ahmo lost consciousness and stopped breathing. His heart stopped beating and he went into cardiac arrest. Medical personnel performed CPR on him in an attempt to revive him. After a heartbeat was detected, Mr. Ahmo was taken to the Grace Hospital. Later that same day, he was transferred to the Health Sciences Centre. Thereafter, he remained intubated in the Medical Intensive Care Unit. He never regained consciousness. On February 14,

2021, life support measures were discontinued, and at approximately 11:24 p.m., Mr. Ahmo was pronounced deceased.

[7] The trial evidence included four Crown witnesses, namely:

1) Michel Jolicoeur, a crisis negotiator that communicated with Mr. Ahmo on February 7, 2021, while he was still in the Homer range;
2) John Kirouac, an Emergency Medical Services paramedic that attended to Mr. Ahmo at HCC;
3) Andrew Barbour, a CERU training coordinator that was qualified to give expert opinion evidence in connection with policy, training, use of force and CERU operations; and
4) Dr. Charles Littman, the forensic pathologist who conducted Mr. Ahmo's autopsy.

[8] There was no evidence called on behalf of the accused.

[9] Further, a total of nine exhibits were filed on the trial.

[10] I take note that the Crown filed a memorandum of law and numerous cases that outline the applicable legal principles for cases involving penal and criminal negligence. I have reviewed that material and also conducted an extensive review of the transcripts of the trial proceedings, the video evidence and the trial exhibits. I have carefully considered all of this material in arriving at my decision.

2) Issues

a) What is not at issue

[11] I will start with an analysis of what is *not* at issue in this case as it relates to both offences. The following admissions and agreements were outlined during the course of the trial:

1) the date of the alleged offences, that being February 7, 2021;
2) jurisdiction, that is that the offences are alleged to have occurred in Headingley, Manitoba;
3) the identity of the accused;
4) the identity of William Ahmo;
5) that the video evidence could be tendered by consent (it was filed as Exhibit 2 on the trial); and
6) that an agreed statement of facts could be tendered by consent (it was filed as Exhibit 1 on the trial).

b) What is at issue

[12] For the offence of criminal negligence causing death, the Crown must prove the following beyond a reasonable doubt:

1) that the accused did something or omitted to do something that it was his legal duty to do (the *actus reus* of the offence);

2) that the accused showed a wanton or reckless disregard for the life and safety of Mr. Ahmo (the *mens rea* of the offence); and

3) that if the accused committed an act or omission that was negligent, that this act or omission caused Mr. Ahmo's death.

[13] The Crown takes the position that the accused ought to have foreseen that Mr. Ahmo was in medical distress after being pulled out of the Homer range by virtue of his repeated statements of not being able to breathe. The Crown argues that this was not simply an error in judgment, but, rather, that this represented a wanton or reckless disregard for the life and safety of Mr. Ahmo and that the accused's negligent act or omission caused Mr. Ahmo's death. The Crown submits that a conviction should result on this count.

[14] For the offence of failing to provide necessaries, the Crown must prove the following beyond a reasonable doubt:

1) that the accused was under a legal duty to provide the necessaries of life to Mr. Ahmo; and

2) that the accused failed without lawful excuse to perform the legal duty imposed by section 215(1)(c) of the *Criminal Code* and thereby endangered the life of Mr. Ahmo or caused his health to be injured permanently.

[15] The Crown takes the position that the accused was under a legal duty to provide medical assistance or treatment to Mr. Ahmo. The Crown further argues

that the accused failed to perform this duty and thereby endangered Mr. Ahmo's life or caused his health to be injured permanently when he was placed in the ERC. The Crown submits that a conviction should also result on this count.

[16] Defence counsel takes the position that the Crown has not proven either charge beyond a reasonable doubt and that acquittals should be recorded on both counts.

3) The Offence of Criminal Negligence Causing Death

a) Applicable *Criminal Code* provisions

[17] Section 219 of the *Criminal Code* states as follows:

> (1) Every one is criminally negligent who
>
> (a) in doing anything, or
>
> (b) in omitting to do anything that it is his duty to do,
>
> shows wanton or reckless disregard for the lives or safety of other persons.
>
> (2) For the purposes of this section, "duty" means a duty imposed by law.

b) Applicable legal principles

[18] There are differences between criminal negligence and failing to provide the necessaries of life. Criminal negligence requires conduct that constitutes a marked and substantial departure from what a reasonably prudent person would do under the circumstances. Failing to provide the necessaries of life requires proof only that the conduct constitutes a marked departure from the standard of care expected of a reasonably prudent person in the circumstances. Criminal negligence requires proof

that the accused showed a wanton or reckless disregard for the life or safety of another, whereas failure to provide the necessaries of life requires proof that the accused's failure endangered the life of the person to whom he or she owed a duty, or that the accused caused, or was likely to cause, the health of that person to be endangered permanently. Criminal negligence is the more serious of the two offences (see *R. v. J.F.*, 2008 SCC 60).

[19] In cases alleging criminal negligence, evidence of training and experience may be used to show how a reasonable person in the circumstances of the accused would have performed the activity (see *R. v. Javanmardi*, 2019 SCC 54).

[20] The following further principles are to be applied in cases alleging criminal negligence:

1) the trier of fact should refrain from relying upon the consequences of the accused's actions when assessing whether the *actus reus* has been proven;
2) there is a modified objective test for assessing the *mens rea* of this offence which is based on the premise that a reasonable person in the accused's position would have been aware of the risk arising from the conduct; and
3) the *mens rea* element for this offence requires an act or omission by the accused which shows a wanton or reckless disregard for the lives or safety of other persons.

4) The Offence of Failing to Provide Necessaries of Life

a) Applicable *Criminal Code* provisions

[21] Section 215(1)(c) of the *Criminal Code* states as follows:

> Every one is under a legal duty
>
> …
>
> (c) to provide necessaries of life to a person under his charge if that person
>
> (i) is unable, by reason of detention, age, illness, mental disorder or other cause, to withdraw himself from that charge, and
>
> (ii) is unable to provide himself with necessaries of life.

[22] Section 215(2) of the *Criminal Code* states as follows:

> Every person commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse to perform that duty, if
>
> …
>
> (b) with respect to a duty imposed by paragraph (1)(c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.

b) Applicable legal principles

[23] The standard in penal negligence cases is based on the reasonable person test. The test can simply be stated as, "What would a reasonably prudent person have done in all of the circumstances?" Penal negligence requires conduct that represents a marked departure from the standard of the reasonable person.

[24] The objective fault element in penal negligence cases is grounded in an accused's failure to direct his/her mind to a risk that a reasonable person would have appreciated. As a result of this, an accused's personal characteristics and

background such as their experience, age and education are not relevant to this assessment, unless there is an incapacity to appreciate the risk. However, the reasonable person must be placed in the relevant circumstances of the accused. These circumstances "do not personalize the objective standard; they contextualize it" (*R. v. Goforth*, 2022 SCC 25 at para. 41).

[25] A trier of fact may consider policy, procedures and legislation that govern the conduct of an accused charged with failing to provide necessaries (see *R. v. Doering*, 2022 ONCA 559 at para. 88).

[26] In penal negligence cases, an assessment of the objective *mens rea* does not factor in what an accused knew or intended, but with what they ought to have foreseen. The Crown therefore does not need to prove subjective *mens rea* such as intent, recklessness or wilful blindness.

[27] In cases of penal negligence, the trier of fact should only consider the *mens rea* element of the offence once satisfied that the *actus reus* of the offence has been committed (see *R. v. Creighton*, [1993] 3 S.C.R. 3 at p. 73-74).

[28] The Crown must prove the *mens rea* of this offence by establishing, on an objective basis, a marked departure from the conduct of a reasonably prudent person having the charge of another in circumstances where it is objectively foreseeable that failure to provide necessaries of life would lead to a risk of danger to the life of

the victim or a risk of permanent endangerment to their health (see *Goforth* at paras. 27 and 30).

[29] The term "necessaries of life" includes prompt medical attention and protection from harm that is reasonably foreseeable and more than minor or transitory (see *Doering* at para. 37).

[30] This offence is risk-based and does not include a causation element. The term "endangers the life of the person" means exposing that person to danger, harm or risk or putting someone in danger of something untoward occurring. It does not require proof of actual harm or injury, just that the person was exposed to danger, harm or risk. The section criminalizes the endangerment of life, not the causation of death.

[31] The charging provision contemplates a defence of lawful excuse that can apply to justify an acquittal even if the elements of the offence are otherwise established.

5) Analysis of the Trial Evidence

a) Was the accused under a legal duty to provide the necessaries of life to Mr. Ahmo?

[32] The first issue relating to the charge of failing to provide necessaries was not contentious and can be addressed summarily.

[33] Section 215(1)(c) of the *Criminal Code* indicates that a person is under a legal duty to provide the necessaries of life to a person under his charge if that person is unable, by reason of detention, to withdraw himself from that charge and is unable to provide himself with necessaries of life.

[34] In Manitoba, provincial correctional officers are under a statutory duty to ensure that inmates are kept safe and secure. Section 2(1)(b) of the *The Correctional Services Act*, C.C.S.M. c. C230, states:

> The purpose of this Act is to contribute to a safe, just and peaceful society by providing for
>
> …
>
> (b) the safe, secure and humane accommodation of persons who are in lawful custody.

[35] The evidence is clear that Mr. Ahmo was incarcerated, and therefore detained, at HCC. As an inmate of a provincial correctional facility, Mr. Ahmo was not able to withdraw himself from that charge. He would have been reliant on correctional staff and authorities to provide him with medical assistance and treatment, which I am satisfied constitute necessaries of life that he was unable to provide himself with while incarcerated.

[36] As a result, I am satisfied that the accused, in his capacity as a correctional officer and captain of the CERU team, was under a legal duty to provide the necessaries of life to Mr. Ahmo.

b) The Testimony of Andrew Barbour

[37] Before I begin my analysis of the remaining issues and evidence in this case, I will make some general observations regarding the testimony of Andrew Barbour.

[38] The Crown called Mr. Barbour and proffered him as an expert witness in CERU operations. Mr. Barbour said that he understood his role as an expert was to provide insight into CERU operations and to provide opinion evidence independently and objectively. Mr. Barbour's *curriculum vitae* was filed as an exhibit on the trial. He answered questions at the start of his testimony regarding his qualifications to give expert opinion evidence, which were conceded by Defence counsel. I ruled that he was qualified to give expert opinion evidence on CERU operations, including policy, training and use-of-force and to provide an expert opinion regarding the CERU response in this case. In so doing, it was the Court's expectation that Mr. Barbour would provide objective, impartial, independent and unbiased testimony.

[39] Two issues arose during the testimony of Mr. Barbour.

[40] First, during Mr. Barbour's cross examination, the Crown sought leave to cross examine Mr. Barbour on re-examination. The Crown relied on the fact that Mr. Barbour agreed with most or many of Defence counsel's suggestions that were put to him on cross examination, and that in fact Mr. Barbour deviated from his direct testimony.

[41] For example, on direct examination, Mr. Barbour testified that HCC was not entitled to deviate from the 2019 Use of Force Policy. On cross examination, Mr. Barbour said that HCC was entitled to deviate from the 2019 Use of Force Policy and that the 2017 Emergency Restraint Chair Policy could be followed.

[42] After hearing counsel's submissions on this issue, I did not grant leave to the Crown to cross examine Mr. Barbour.

[43] Second, Defence counsel asked Mr. Barbour whether the accused performed as a reasonable CERU captain in the rotunda. The Crown objected to this question being asked, because this is the ultimate issue for the Court to rule on. While I allowed the question to be asked, I indicated at the time of my ruling that I would later consider the weight to be given to Mr. Barbour's testimony on this point.

[44] Having had an opportunity to consider the matter further, the unusual nature of the circumstances of this case required that this question be permitted. In my view, Mr. Barbour's testimony on this point is not determinative of the issue or the outcome of this trial, but his testimony is an important factor in the Court's assessment. I must remember that this incident occurred in a prison setting. It involved individuals that work in that environment and who are bound by legislation, policies, procedures and chains of command. The incident involved an unruly inmate amidst concerns about safely ending a stand-off. This was not a situation that arises in the common, everyday experience of most members of

society, such that the Court can simply apply its common sense alone. It is important to have Mr. Barbour's special knowledge as a CERU operations expert to provide important evidence and opinions that are outside of the knowledge and experience of this Court, in order for the Court to better understand the context within which this incident occurred. It is only with this perspective in mind that I am able to properly assess whether the accused acted as a reasonable CERU captain in this case.

[45] Mr. Barbour's answer to Defence counsel's question was that the accused "made decisions based off his interpretation of the incidents that would be in line with reasonability" (Transcript of Proceedings, September 7, 2023, Volume 4, Page T60, Lines 36-40). My interpretation of Mr. Barbour's response is that he believes that the accused performed as a reasonable CERU captain in the rotunda on February 7, 2021. His opinion in this regard is of course his own, and, as I have already indicated, is not one that is determinative of the issues before me on this trial. In fact, I am mindful of the Crown's argument that Mr. Barbour's overall opinion of what transpired on February 7, 2021, is likely based, at least in part, on evidence that is not before me on this trial. Contrary to the position of the Crown, I find that Mr. Barbour provided testimony that was objective, impartial, independent and unbiased. I am of the view that there is no basis for me to reject his testimony in whole or in part, or that his testimony should carry reduced weight. In fact, Mr. Barbour's testimony is consistent with the other evidence in this case.

[46] That being said, I have arrived at my conclusions in this case by accepting various parts of Mr. Barbour's evidence that provide the Court with important context and other details. I have made my decision by closely examining all of the evidence before me, and not by simply endorsing Mr. Barbour's conclusion that the accused performed as a reasonable correctional officer and CERU captain in the rotunda.

c) Policies

[47] Counsel addressed the potential conflict in the correctional policies that were filed in this case. I will provide a short summary of the policies and my findings on the apparent conflict.

i) Manitoba Corrections Use of Force Policy, dated January 2019

[48] A copy of this policy ("the 2019 policy") was filed as Exhibit 5 on this trial. This policy was in effect on February 7, 2021, according to Mr. Barbour. This policy applied to all correctional officers and CERU units in Manitoba, and therefore applied to HCC.

[49] Section 1 of the policy describes the purpose of this policy as follows:

1) to define the authority for the use of force in correctional centres;
2) to define force options, authorized equipment and the criteria for appropriate use of force; and

3) to define use of force training requirements and interventions for incident recovery.

[50] Appendix B of the policy states that the purpose of using the ERC is as a temporary measure to stop self-harming behaviour by physically incapacitating an inmate and that its use must be authorized by a senior manager and is only to be used by a designated/trained correctional officer.

[51] Section 7 of the policy states that all correctional officers are trained in the use of the ERC, which is a described as a "type" of mechanical restraint. Mr. Barbour also confirmed this training. He also confirmed that CERU members do not train with the ERC, but that all CERU members are correctional officers. I infer from this evidence that all members of CERU would have been trained in the use of the ERC, and that includes the accused and those CERU members that handled the ERC in this case. Mr. Barbour also testified that the accused was an instructor in connection with the ERC. I am also prepared to infer that on February 7, 2021 the accused was aware that all members of the CERU team had received training on the ERC in their capacity as correctional officers, as required by this policy.

[52] Section 10 of the policy states:

> Every custody centre will draft standing or post orders in accordance with this policy.

ii) HCC Standing Order – Emergency Restraint Chair Policy, dated January 17, 2017

[53] A copy of this policy ("the 2017 policy") was filed as Exhibit 6 on this trial. Paragraphs 1 and 2 of this policy state that the purpose of the policy is twofold:

1) to provide for the use of a restraint chair to protect correctional officers and others from an offender's violent behaviour; and
2) to regain control over offenders who act disruptively and who pose an immediate threat to the security at HCC.

[54] Paragraph 4 states that only a Correctional Supervisor, Unit Manager or Shift Operations Manager may authorize an offender's placement in the ERC. Use of the ERC is to be determined using the following criteria:

1) there is an immediate need to prevent the offender from injuring himself or others;
2) using the ERC will prevent him from causing serious property damage; and
3) the ERC must be used to maintain control while moving a high-risk offender within the facility.

[55] The policy is 11 pages in length. It sets out detailed requirements, conditions and procedures for using the ERC.

iii) Findings

[56] On direct examination, Mr. Barbour was asked about the 2017 policy. Despite section 10 of the 2019 policy requiring institutions to draft or update their standing orders to accord with the 2019 policy, HCC did not update the 2017 policy. Mr. Barbour was of the view that CERU members likely would have operated on the basis of the 2017 policy and therefore not on the 2019 policy (see Transcript of Proceedings, September 6, 2023, Volume 3, Page T37).

[57] On cross examination, this point was clarified by Mr. Barbour. He stated definitively that on February 7, 2021, HCC was operating on the basis of the 2017 policy (see Transcript of Proceedings, September 6, 2023, Volume 3, Pages T87-T89).

[58] I accept Mr. Barbour's testimony that the 2017 policy was still in place on February 7, 2021, and that it had not been rescinded, amended or updated as of that date. The Court has not been provided with any explanation as to why this did not occur or who was responsible for this. I accept Mr. Barbour's testimony that on February 7, 2021, HCC correctional officers, and therefore CERU members, were operating on the basis of the 2017 policy. This is a reasonable conclusion to arrive at based on the evidence. This is an important point given that the 2017 policy contains clauses that clearly stand in conflict with the 2019 policy. Specifically, the 2017 policy allows the ERC to be used to maintain control while moving a high-risk

inmate within a facility, while the 2019 policy allows the ERC to be used only as a temporary measure to stop self-harming behaviour by physically incapacitating an inmate.

[59] As the trier of fact, I am able to consider the policies, procedures and legislation that governed the conduct of the accused in this case. This provides important context when I consider the objective fault element in this case. What this means in this case, is that I must consider the conduct of the accused on February 7, 2021 in the context of the 2017 policy. I will have more to say about this later.

d) The events prior to CERU's entry into the Homer range

i) February 7, 2021, 12:30 p.m. to 3:45 p.m.

[60] The various principles regarding penal negligence and criminal negligence outlined above must be applied in the context of the particular circumstances of this case. In other words, these principles must be applied in the context of the activity or activities surrounding Mr. Ahmo and the accused. It is therefore important to consider the events in the few hours prior to CERU's entry into the Homer range. These events were captured on video. I also heard the testimony of the crisis negotiator, Mr. Jolicoeur, which I accept. What follows is a brief summary of these events.

[61] The accused was the captain of the CERU team on February 7, 2021. A plan was created to end the stand-off. The accused was responsible for giving

instructions, updating the command post and essentially leading the team as the plan was executed. However, it is clear that there were numerous individuals that were present and involved or were decision-makers in the events that occurred that day, many of whom were not called as witnesses during this trial. This includes numerous other members of the CERU team, the two nurses that attended to Mr. Ahmo and the individuals stationed at the command post.

[62] There was an initial confrontation in the Homer range between Mr. Jolicoeur, Mr. Allen and Mr. Ahmo. Mr. Allen pepper sprayed Mr. Ahmo. Mr. Ahmo reacted in a state of rage, his eyes were bulging and his veins were popping. He approached Mr. Jolicoeur and Mr. Allen with a weapon and made threatening comments. Mr. Jolicoeur and Mr. Allen were scared for their lives, as Mr. Ahmo seemed motivated to hurt them.

[63] Mr. Ahmo's behaviour included yelling, screaming, banging, pacing and throwing things. He made comments to the effect that he would die and go to heaven, that he had committed violent acts of rape and had cut off someone's hand, that he would kill anyone that came through the door and into the Homer range, that he believed that he was in a war, that he was not afraid to die, and that he would not go peacefully. Mr. Jolicoeur believed that Mr. Ahmo was experiencing a mental health crisis.

[64] Mr. Ahmo's behaviour initially led to a Code 33, meaning that a guard that was trapped in the Homer range was considered to be in imminent danger and in a potentially life-threatening situation. Beginning at approximately 12:30 p.m. that day and for several hours thereafter, Mr. Ahmo was agitated, aggressive and assaultive. His behaviour and demeanour was also threatening, particularly as he wielded and swung a stick around as a weapon. He destroyed property within the range. I accept that his behaviour followed a similar, ongoing pattern of being agitated and aggressive, with periods of being tranquil and quiet, and then followed again by being agitated and aggressive, and so on.

[65] I note that Mr. Ahmo was a large man – he was approximately 5 feet, 11 inches tall and weighed 244 pounds. He exhibited enormous strength, particularly during his interactions with the CERU team. He ripped a hot water tank unit off of the wall in Homer, something that Mr. Jolicoeur indicated would require a great deal of strength. Also, a stinger grenade was thrown at Mr. Ahmo when CERU first entered Homer, and it had little effect on slowing Mr. Ahmo down.

[66] Based on his words and actions, it is clear that Mr. Ahmo had demonstrated dangerous and violent behaviours prior to the CERU team entering the Homer range, regardless of whether he was having a mental health crisis. The interaction between Mr. Ahmo, Mr. Jolicoeur and Mr. Allen when Mr. Ahmo was pepper sprayed would

have provided ample reason to believe that the stand-off would not end in a peaceful manner despite best efforts.

[67] After the pepper spray and pepper balls had already been deployed in Homer, it became known that an inmate in the Homer range was allergic to pepper. This created an urgency to end the stand-off. The Crown concedes that the circumstances made it necessary for CERU to go in and end the stand-off, and I agree that it became necessary to do so.

ii) CERU SMEAC Worksheet

[68] The involvement of the CERU team led to the creation of a plan to enter the Homer range. This plan was outlined in writing in a document called a CERU SMEAC Worksheet ("SMEAC"), a copy of which was filed as Exhibit 9 on this trial.

[69] Mr. Barbour testified that the SMEAC is a document that is prepared when CERU is deployed. The acronym "SMEAC" stands for Situation Mission Execution Administration Command. The CERU captain collaborates with the CERU coordinator to develop a tactical plan and a coordinated response to resolve incidents that CERU is deployed to. The SMEAC is a fillable form that outlines the planned response to a particular incident. The CERU captain will often draft this document, which is then reviewed and authorized by the CERU coordinator and crisis manager. Once authorized, the CERU captain is the one that is in command and in control of

the team on the scene. A CERU captain is allowed to make decisions for the team that deviate from a SMEAC if the circumstances on the ground change or require it. The CERU captain has the delegated authority to make those decisions if required and without communicating that different plan of action with the command post.

[70] Mr. Barbour reviewed the SMEAC that was prepared with respect to the CERU deployment in this case. The SMEAC was handwritten, and it was signed by the accused, the CERU coordinator (Richard Heuchert) and the crisis manager (Cindy Schultz). Those are the three individuals that should have been involved in drafting the SMEAC in this case, according to Mr. Barbour.

[71] The SMEAC in this case provided a summary of the situation at hand – an inmate was loose in the unit with weapons and was pacing, a table was pressed up against the door and there was broken glass in the unit.

[72] The SMEAC also provided the mission, namely, to safely secure the inmate and relocate him to segregation using the least amount of force. The execution of this plan was laid out in three parts and can be summarized as follows:

1) execution #1 – elicit cooperation through communication and relocate to segregation to begin the recovery plan;
2) execution #2 – gain compliance through introduction of pepper spray and gain control of the inmate using mechanical restraints, remove to decontamination and then to segregation; and

3) execution #3 – using a combination of shields, batons, stingers, DD's, pepper ball gun and hand controls, gain control of the inmate, decontaminate and move to segregation, and then begin the recovery plan.

iii) The accused's knowledge of the events prior to CERU's entry into the Homer range

[73] One question that must be answered is whether the accused was aware of the full extent of Mr. Ahmo's behaviour prior to the CERU team entering the Homer range that day. The Crown takes the position that there is no evidence before the Court that the accused was present to observe those events himself or that he was briefed or made aware of what had happened.

[74] With respect, I disagree with the Crown's position on this point.

[75] It is accurate to say that there is no direct evidence that the accused was present or that he was briefed, but I am prepared to draw an inference that the accused knew what had happened and was planning the CERU team's entry and subsequent steps based on Mr. Ahmo's behaviour and the events in the preceding hours. I say this for the following reasons.

[76] Mr. Barbour testified that CERU members are trained to assess threats based on a person's current behaviours and on that person's past behaviours. Mr. Barbour also testified that if consistent patterns of behaviour have been displayed, it would be reasonable to expect those behaviours to continue.

[77] Mr. Barbour also testified that the SMEAC is typically drafted by the CERU captain, but it is signed by the CERU coordinator, the crisis manager and the CERU captain.

[78] In this case, I am satisfied that in order to draft a SMEAC that properly responded to the situation in Homer range, a threat assessment would have been required. This would have required, at a minimum, information about the history of Mr. Ahmo's behaviour in the preceding hours. As one of the individuals who signed off on the plan outlined in the SMEAC, I am satisfied that the accused would have been made aware of what Mr. Ahmo had said and done in the Homer range that afternoon, and therefore would have had a sense of Mr. Ahmo's violent and aggressive pattern of behaviour that day. It would have been foolish to formulate a plan to be executed by the accused and the CERU team without knowing details of the situation that they were walking into. Such an approach would defy common sense.

[79] Further, the contents of the SMEAC itself provides insight into the accused's knowledge. The first paragraph provides a brief synopsis of the situation that Mr. Ahmo presented – an inmate loose in the unit with weapons and pacing, tables pressed up against the door and the glass to the rotunda is broken. The plan was to gain compliance by using pepper spray and to safely secure Mr. Ahmo, decontaminate him and move him to segregation using the least amount of force.

The SMEAC also outlined a plan to gain control of Mr. Ahmo using mechanical restraints. The overall plan suggests the need to use force, albeit the least amount necessary, and to gain control and compliance over an individual who was armed and had caused damage to the range. All of this information suggests that the accused knew that he was dealing with an individual who was violent and difficult to control. The SMEAC was signed by the accused.

[80] This knowledge is important in how the accused and the CERU team approached the situation with Mr. Ahmo and how and why they dealt with him in the manner that they did in the rotunda.

e) The events after CERU's entry into the Homer range

i) Video clip 2E – CERU 81

[81] There were a total of six video clips on the USB drive that was filed as Exhibit 2 on this trial. Video clip 2E is the most important portion of the video evidence, as it shows the CERU team's entry into the Homer range and the subsequent interaction with Mr. Ahmo in the rotunda area.

[82] The video recording for this clip begins at 3:45 p.m. The clip is 20 minutes and 52 seconds in length. It includes audio and very good quality colour video. It was recorded by a hand-held camera operator that followed CERU from the rotunda and into the Homer range, and then back out into the rotunda once Mr. Ahmo was moved there. A transcript of the video was filed as Exhibit 8 on the trial. I had the

benefit of watching and replaying various portions of the video with the assistance of the transcript. It is clear that the accused was present throughout the video. It is also clear that he was mindful of what was transpiring with Mr. Ahmo and was in a position to hear what Mr. Ahmo said throughout.

[83] A review of video clip 2E and the entirety of the video evidence demonstrates Mr. Ahmo's aggressive and combative tendencies prior to and after the CERU team's entry into the Homer range. Video clip 2E also discloses the obvious concerns that the accused and the CERU team had about Mr. Ahmo reinitiating his combativeness after appearing to remain calm at times while they were trying to subdue and restrain him. These concerns were evident based on the actions and reactions of the CERU team (including the accompanying discussion) and the fact that they were watching for Mr. Ahmo's combative nature to resurface and bracing themselves for that.

[84] My references to various portions of video clip 2E throughout my decision will refer to the running time of the clip (the start of the clip is 0:00).

ii) Pepper spray, pepper balls and Mr. Ahmo's ability to breathe

[85] Pepper spray was an important factor in what took place on February 7, 2021.

[86] Pepper spray was initially deployed by Mr. Allen into the Homer range. The ventilation system was shut off to maximize the effect of the pepper spray on Mr. Ahmo. Later on, when Mr. Ahmo appeared to be passing objects to another inmate

who was locked in his cell, pepper balls were fired into the Homer range. The presence of the pepper spray inside the Homer range created an urgency to end the stand-off because one of the other inmates inside the range was allergic to pepper. A pepper ball was also fired into the Homer range just before the CERU team entered.

[87] Dr. Littman testified that the pepper spray affected the accused's ability to breathe. A review of video clip 2E discloses that Mr. Ahmo said that he could not breathe on approximately 20 to 30 occasions over the course of about seven minutes.

[88] Mr. Barbour testified that individuals who have been pepper sprayed will often feel like they cannot breathe, and that one way of reassuring them that they can is to remind them that if they can talk, then they can breathe. This is a phrase that the accused said to Mr. Ahmo while in the rotunda when Mr. Ahmo said that he could not breathe. The SMEAC that the accused signed in this case clearly contemplated the need to decontaminate Mr. Ahmo, particularly since the plan outlined in the SMEAC called for the use of pepper spray upon the CERU team entering Homer.

[89] Mr. Barbour testified that all correctional officers are pepper sprayed in the course of their training. The accused would have had this training in his capacity as a correctional officer. That being said, I recognize that training and experience cannot, strictly speaking, be factored in when assessing the objective fault element.

However, the *Goforth* decision makes it clear that the reasonable person must be placed in the relevant circumstances of the accused, which does not personalize the objective standard, but contextualizes it. In my view, this requires the reasonable person to be placed in the relevant circumstances of the accused, which includes his training and experience with pepper spray. The notion of saying words to the effect of "if you can talk, you can breathe" to a person who has been exposed to pepper spray is therefore context that must be considered when assessing the objective fault element and what a reasonable correctional officer would have done. In my view, there was every reason to believe that Mr. Ahmo's comments about not being able to breathe was as a result of the pepper spray, particularly given that Mr. Ahmo continued to fight, resist and struggle, and given that Mr. Ahmo can be seen breathing heavily at times on the video by virtue of his chest contracting in and out – something that would have been visible to those that were present in the rotunda, including the accused.

iii) Medically trained staff

[90] The Crown argues that the accused should have recognized that Mr. Ahmo was in need of medical treatment. In this particular case, the accused had access to medically trained individuals while the CERU team dealt with Mr. Ahmo in the rotunda.

[91] On video clip 2E, at 7:41, the accused called for Nurse Mark Janik to make sure that Mr. Ahmo could breathe. I note that Mr. Ahmo had only said once to that point that he could not breathe. Nurse Janik examined Mr. Ahmo and said that he was breathing. The accused said, "Is he good?" Nurse Janik replied by saying, "He's good now." The accused immediately reported to the command post that Mr. Ahmo had been medically cleared and that they were going to put him in the ERC. I accept Mr. Jolicoeur's evidence that Nurse Janik was a very experienced nurse.

[92] Two members of the CERU team that day had medical training. Paul Cheema was a first responder, and Dave Burt was an instructor in CPR and first aid. In fact, Mr. Burt instructed the nurses at HCC. This evidence came out through Mr. Barbour. I accept his testimony on these points. In other words, this is based on his knowledge of the backgrounds of Mr. Cheema and Mr. Burt and is therefore admissible evidence.

[93] On video clip 2E, Nurse Michelle Tully came in at approximately 17:41. The accused asked the other members of the team when the nurse could get in to examine him. The response was that the team was still securing him. At 18:05, Nurse Tully said "He's moving… I can see him moving so we're good." The accused asked her, "Ambulance, or no?" She responded with, "No, I think. I'll have a look." At 19:09, Nurse Tully attempted to wake or stir Mr. Ahmo without success.

[94] The accused had medically trained personnel at his disposal, and was entitled to rely on their medical assessments and opinions. The two nurses and the two CERU members did not alert the accused to Mr. Ahmo having any medical issues that required urgent medical attention. A proper and more fulsome assessment of Mr. Ahmo by medical personnel might very well have disclosed concerns, but in my view a closer assessment was not possible given that Mr. Ahmo continued to struggle and resist while in the rotunda.

iv) Emergency Restraint Chair

[95] Part of the plan outlined in the SMEAC is that Mr. Ahmo was to be taken to an area to be decontaminated from the pepper spray. This area was about 200 metres away. The plan was to put Mr. Ahmo in the ERC and wheel him there.

[96] Mr. Barbour testified regarding the use of the ERC in this case and generally at HCC. I accept his testimony regarding the ERC and the applicable policies.

[97] Mr. Barbour testified that the ERC provided the greatest degree of control to safely transport Mr. Ahmo to the decontamination area. Mr. Ahmo would be sitting at 90 degrees once seated in the ERC, which would provide him with a good position for air flow. The accused was in fact encouraging his team to keep Mr. Ahmo at 90 degrees. That being said, I accept Mr. Barbour's testimony that it is difficult enough to put someone in the ERC when they are compliant, but that it is even more difficult if they are not.

[98] Mr. Barbour testified that HCC was operating under the 2017 policy at the time of this incident. He said that each institution takes the Use of Force Policy and adapts it to meet their operational needs. That being said, the 2017 policy was not updated based on the 2019 policy. The end result is that there is a clear conflict in the policies regarding the ERC, but that the 2017 policy remained in force at the time of this incident. According to Mr. Barbour, CERU was within the 2017 policy in attempting to move Mr. Ahmo using the ERC.

[99] While the 2017 policy indicates that CERU does not train with the ERC, it is clear that the policy says that correctional officers receive training on it. All CERU members are correctional officers, so while CERU members do not train with the ERC, they would have received such training in their capacities as correctional officers.

[100] In this case, the SMEAC outlined a plan to control Mr. Ahmo using "mechanical restraints", which Section 7 of the 2017 policy defines to include an ERC. That SMEAC was signed by the accused, the CERU coordinator and the crisis manager.

[101] Further, at 8:04 of video clip 2E, the accused told the command post that Mr. Ahmo had been cleared medically by a nurse and that they were putting Mr. Ahmo in the ERC. This was contemplated by the plan laid out in the SMEAC and no one from the command post objected to this course of action. The command post was

the senior management of HCC. This included Ms. Duncan (the superintendent of HCC), Richard Heuchert (the CERU coordinator) and Ms. Schultz (the crisis coordinator).

[102] Finally, Mr. Barbour confirmed that a prisoner should be kept in handcuffs and leg irons when they are put in the ERC because the handcuffs connect to the tether or hook at the back of the ERC. Mr. Barbour's testimony is confirmed by the instructions within the 2017 policy.

[103] In this case, it is clear that, at approximately 5:26 of video clip 2E, Mr. Ahmo was wearing leg shackles and his hands were cuffed behind his back. He continued to struggle by turning his body and kicking his legs. At 6:36, the accused asked for the ERC. At 9:34, Mr. Ahmo was placed in the ERC. At 9:40, Mr. Ahmo said, "I can't breathe" five times in short succession. In the course of this, the accused said to Mr. Ahmo twice, "If you're talking to us you can breathe." Mr. Ahmo moaned and said, "I'm choking."

[104] Attempts were then made to secure Mr. Ahmo to the ERC. Mr. Ahmo can be heard moaning during this time. It is also clear from the video that he was breathing heavily.

[105] At 10:37, the accused yelled twice to Mr. Ahmo, "Be quiet!" Mr. Ahmo responded by saying, "I can't breathe" four times. The accused then said, "Stop moving." Mr. Ahmo responded by saying, "I'll stop moving if you let me breathe."

[106] At 16:27, Mr. Ahmo is then heard to be snoring, which the accused noted. Dr. Littman testified that this was agonal breathing and not snoring, although I note that it would have appeared to the untrained eye that Mr. Ahmo was sleeping and snoring. At 16:34, the accused noted that this was a good opportunity to put Mr. Ahmo back in the ERC if he was asleep and presumably not combative and resisting as he had been earlier. Mr. Ahmo was placed in the ERC again at approximately 17:00. He was removed from the ERC at approximately 20:12.

v) Mr. Ahmo's cause of death

[107] As it relates to the charge of criminal negligence causing death, Mr. Ahmo's cause of death was not contentious. I accept Dr. Littman's testimony regarding Mr. Ahmo's cause of death.

[108] Dr. Littman testified that Mr. Ahmo's death was caused by a brain injury. That brain injury occurred due to a lack of oxygen and a lack of blood supply due to cardiorespiratory arrest. In other words, his heart stopped and he stopped breathing. That being said, Dr. Littman testified that the cause of Mr. Ahmo's cardiorespiratory arrest was a combination of factors as part of a complex process. This included physiological stress, as he had been extremely agitated and aggressive and therefore exhausted as a result. This contributed to his heart stopping. The pepper spray also made his breathing more difficult.

[109] Further factors that contributed to Mr. Ahmo's death were discovered during his autopsy. His heart was at the very upper limit of normal for his size. An enlarged heart is more prone to suffering a cardiac arrest. In addition, he was described as being obese, which would have affected his ability to move his diaphragm and breathe. While these factors were not directly the cause of his cardiac arrest, they contributed to his death.

[110] There was also restraint used in the prone position, which would have caused a degree of mechanical and positional difficulty in breathing or asphyxia. Mechanical asphyxia means that there is pressure placed on the chest and abdomen so that the chest and abdomen cannot move effectively. The position component is being placed face down, which also affects the ability to breathe effectively.

[111] Increased muscular activity causes anaerobic glycolysis. This means that the body produces more lactic acid than it should, and to compensate for that, a person will try to breathe deeper to get rid of carbon dioxide to compensate for the acidosis. Mr. Ahmo's agitation combined with increased muscular activity required him to breathe deeper and more frequently to blow off carbon dioxide.

[112] Dr. Littman noted that there are particular dangers of mechanical or positional restraint in individuals like Mr. Ahmo who are overweight. The dangers are that they cannot breathe effectively, so they are more likely to produce more lactic acid and then become unable to compensate for that by blowing off carbon dioxide. That

is because the chest is not able to expand to take in the air and then release the carbon dioxide. Breathing requires movement of the chest and the diaphragm. In an obese individual, the chest and diaphragm do not move as effectively if the person is placed in a prone position. The heart stops because the acidosis has a direct effect on the electrical system of the heart, causing a cardiac arrest. Also, there is a lack of oxygen to the brain, which also contributes to the heart stopping.

f) Conclusions

i) Findings

[113] Crown counsel and Defence counsel have differing assessments of what conclusions the Court should draw from the evidence in this case.

[114] The Crown takes the position that the accused ought to have foreseen that Mr. Ahmo was in medical distress after being pulled out of the Homer range by virtue of his repeated statements of not being able to breathe. The Crown argues that this was not simply an error in judgment, but, rather, that this represented a wanton or reckless disregard for the life and safety of Mr. Ahmo and that the accused's negligent act or omission caused Mr. Ahmo's death. The Crown submits that a conviction should result on the charge of criminal negligence causing death.

[115] Also, the Crown takes the position that the accused was under a legal duty to provide medical assistance or treatment to Mr. Ahmo, and that this amounted to a necessary of life. The Crown further argues that the accused failed to perform this

duty and thereby endangered Mr. Ahmo's life when he was put in the ERC. The Crown submits that a conviction should also result on the charge of failing to provide the necessaries of life.

[116] Defence counsel takes the position that the evidence demonstrates that Mr. Ahmo resisted and struggled from the time that he was in Homer to when he was in the rotunda. Defence counsel submits that the evidence shows that medical input was provided by two nurses and two members of the CERU team who had medical training, and that the accused had no reason to not trust or to not rely on their input regarding Mr. Ahmo's condition. Defence counsel also takes the position that use of the ERC was permitted by both the 2017 policy and the SMEAC.

[117] In my view, the fact that Mr. Ahmo said that he could not breathe on numerous occasions and that seemingly there was no medical assistance offered to him, standing alone, is not determinative in this case. Those details do not tell the whole story. A much more detailed review of the evidence is required to fully assess the matter.

[118] It is clear that Mr. Ahmo was combative immediately when CERU entered the Homer range, and remained combative in the rotunda area. The video shows that Mr. Ahmo continued to struggle and resist, even though he was surrounded by numerous members of the CERU team, and even while he was cuffed and shackled. This can be seen on video clip 2E, not just by watching Mr. Ahmo's actions, but

also by watching the actions of the CERU team and by the words used by the accused and other members of the team as the events unfolded. It is clear that they were mindful of Mr. Ahmo's combative state, his periods of resting and being calm, and then starting to struggle and resist again. I accept Mr. Jolicoeur's testimony that sometimes handcuffing and shackling a prisoner is not enough to prevent them from hurting others. I also accept the general notion that the job of a correctional officer working in a prison environment amongst inmates is inherently dangerous, and that correctional officers are keenly aware of that fact.

[119] The Crown argues that a reasonable correctional officer would have recognized that Mr. Ahmo was in need of medical treatment, and that the focus of the accused and the CERU team was instead on control and restraint. His combative nature up to that point makes it difficult to understand how medical treatment could have been administered to Mr. Ahmo if he did not calm down long enough for that to happen. The CERU team was in fact focussed on control and restraint, and in my view, that was reasonable and necessary given Mr. Ahmo's pattern of combativeness. Mr. Ahmo demonstrated a consistent pattern of fighting, resisting and being combative, and that this would have been apparent to all members of the CERU team that were attempting to restrain him. I find that it was reasonable for the accused and the CERU team members not to trust Mr. Ahmo even when he showed signs of being calm.

[120] A plan had been developed prior to entering Homer that pepper spray and mechanical restraints (which included the ERC) would be used to gain control of Mr. Ahmo. This plan was documented in the SMEAC, which was signed by the accused, the CERU coordinator and the crisis manager. The 2017 policy allowed for the ERC to be used to move a high-risk offender within the facility. The command post was aware of the planned use of the ERC in this case, and no one objected to its use by the accused or by the CERU team. I find that what occurred in this case was done according to the 2017 policy and that the plan was implemented and executed in accordance with the documented SMEAC.

[121] Mr. Ahmo had been subjected to pepper spray or pepper balls on three occasions on February 7, 2021. It clearly affected his ability to breathe. The accused was aware that Mr. Ahmo needed to be decontaminated from the pepper spray and pepper balls. This provides important context for the accused's response to Mr. Ahmo saying that he could not breathe.

[122] The accused was surrounded by medical personnel that he was entitled to rely upon. Mr. Ahmo was initially viewed by a nurse. The accused was entitled to rely on the nurse's opinion. The accused also had medical personnel on the CERU team that the accused would have been entitled to rely upon as they dealt with Mr. Ahmo. However, medical intervention would have only been possible if Mr. Ahmo had not been combative and had not resisted in the manner that he did.

[123] At some point in the rotunda, according to Dr. Littman, Mr. Ahmo was experiencing the complex biochemical process that made it difficult for him to breathe. This process led up to Mr. Ahmo's agonal breathing, or his last breath or breaths, which can be heard at 16:27 of video clip 2E. On cross-examination, Dr. Littman agreed that, to an untrained person, the sound of agonal breathing would appear as though someone was snoring while sleeping. In fact, the accused was present for Mr. Ahmo's agonal breathing and said, "he's snoring" and " … let's take this opportunity to stick him in the chair then if he's asleep". It is not unreasonable for a layperson to conclude that Mr. Ahmo was asleep. I, as a layperson, came to the same conclusion until Dr. Littman explained what was happening.

[124] After a careful, thorough review of the evidence in this case in the context of the jurisprudence on criminal negligence and penal negligence, I am not persuaded that the objective fault element has been proven beyond a reasonable doubt for either charge. I am not satisfied that the accused did not act as a reasonable correctional officer or CERU captain on February 7, 2021.

ii) Criminal Negligence Causing Death

[125] When I look at the elements of the criminal negligence causing death charge, I come to the following conclusions:

1) the accused, as a correctional officer, was bound by a duty imposed by Section 2(1)(b) of *The Correctional Services Act* to keep Mr. Ahmo safe and secure;

2) the accused's conduct did not constitute a marked and substantial departure from what a reasonably prudent correctional officer or CERU captain would have done in the circumstances that the accused was faced with;
3) a reasonable correctional officer or CERU captain in the position of the accused would not have been aware of the risk arising from the accused's conduct;
4) the accused's conduct did not demonstrate a wanton or reckless disregard for the life or safety of Mr. Ahmo; and
5) I am therefore not persuaded beyond a reasonable doubt that the accused showed a wanton or reckless disregard for the life and safety of Mr. Ahmo.

iii) Failure to Provide Necessaries of Life

[126] When I look at the elements of the failure to provide the necessaries of life charge, I come to the following conclusions:

1) in his capacity as a correctional officer and captain of the CERU team, the accused was under a legal duty to provide the necessaries of life to Mr. Ahmo, and that this included medical assistance and treatment;
2) the accused's conduct did not constitute a marked departure from the standard of care expected of a reasonably prudent correctional officer or CERU captain in the circumstances that the accused was faced with;

3) that the accused did not fail to direct his mind to a risk that a reasonably prudent correctional officer or CERU captain would have appreciated; and
4) accordingly, I am not persuaded beyond a reasonable doubt that the accused failed to provide the necessaries of life to Mr. Ahmo.

6) Decision

[127] The death of William Ahmo represents a terrible tragedy. What occurred on February 7, 2021 at HCC has no doubt had, and will continue to have, an immeasurable and lasting impact on the loved ones that Mr. Ahmo left behind. My deepest and sincere sympathies go out to his family, friends and all those who cared about him.

[128] As I indicated earlier in my reasons for decision, I only heard from a small number of witnesses during this trial. There were many other individuals involved in the events of February 7, 2021 that did not testify at this trial. A full assessment of each individual's involvement in this incident and how that may have contributed to the outcome that day is beyond the scope of this decision. My task during this trial was to consider the evidence that was presented in the context of the charges against the accused, Robert Morden. For the reasons that I have articulated, the evidence before me does not satisfy me of Mr. Morden's guilt beyond a reasonable

doubt on either of the two charges before me. Accordingly, acquittals will be recorded on both counts listed on the information.

Original signed by Judge Cellitti

ANTONIO CELLITTI, P.J.