Commission for Public Complaints Against the Royal Canadian Mounted Police

Commission des plaintes du public contre la Gendarmerie royale du Canada

Chair-Initiated Complaint and Public Interest Investigation Regarding the In-Custody Death of Mr. Clay Willey

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Final Report

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Canada

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CHAIR'S FINAL REPORT AFTER COMMISSIONER'S NOTICE
Royal Canadian Mounted Police Act
Subsection 45.46(3)

File No.: PC-2009-3397

CHAIR'S FINAL REPORT AFTER COMMISSIONER'S NOTICE

THE COMPLAINT

On July 21, 2003, Mr. Clayton Alvin Willey was arrested by members of the Prince George RCMP Detachment in British Columbia. Mr. Willey was aggressive with the members. During the arrest, he was pepper-sprayed, punched and kicked before the handcuffs could be applied. Even in handcuffs, the struggle continued, leaving members with the need to bind his legs. After being transported to the detachment, Mr. Willey continued to strain against his restraints, causing two members to use their conducted energy weapons (CEWs) on him. Shortly thereafter, a decision was made to transport Mr. Willey to the hospital. Mr. Willey went into cardiac arrest in the ambulance and died the following morning.

In recognition of public concerns expressed about the use of force by RCMP members, the Commission for Public Complaints Against the RCMP (the Commission) will on occasion exercise its authority in representing the public interest to examine in depth the facts that give rise to the public's concern as well as the adequacy of the RCMP's investigation of the events in question. On January 15, 2009, the Chair of the Commission for Public Complaints Against the RCMP initiated a complaint and a public interest investigation pursuant to subsections 45.37(1) and 45.43(1) of the *Royal Canadian Mounted Police Act* (RCMP Act) into the conduct of those unidentified RCMP members present at, or engaged in, incidents which have taken place anywhere in Canada between January 1, 2001 and January 1, 2009, where individuals in the custody of the RCMP died following the use of a CEW. The arrest and subsequent death of Mr. Willey in Prince George, British Columbia, on July 22, 2003, is one of the incidents covered by that complaint. The original complaint was initiated to examine:

1. whether the RCMP officers involved in the aforementioned events, from the moment of initial contact with the individual until the time of each individual's death, complied with all appropriate training, policies, procedures, guidelines and statutory requirements relating to the use of force; and

2. whether existing RCMP policies, procedures and guidelines applicable to such incidents are adequate.

Mr. Willey's death was the subject of a coroner's inquest conducted by the British Columbia Coroner's Service in October 2004. One of the pieces of evidence considered at the coroner's inquest was a compilation of video footage from a number of security cameras located throughout the Prince George RCMP Detachment. Subsequent to the launch of the Chair's complaint and public interest investigation, the Solicitor General of British Columbia, on behalf of the residents of British Columbia, raised concerns directly with the Chair regarding

this incident and in particular with respect to the integrity of the video evidence relating to the arrest and detention of Mr. Willey.

As a result, the Chair expanded the public complaint and public interest investigation to examine:

3. whether the RCMP members involved in the investigation of Mr. Willey's arrest and subsequent death conducted an investigation that was adequate, and free of actual or perceived conflict of interest; and

4. whether any other video evidence (other than the compilation video referred to above) exists and whether any RCMP member concealed, tampered with or otherwise inappropriately modified in any way, any evidence, in particular any video evidence, relating to the arrest of Mr. Willey.

THE COMMISSION'S PUBLIC INTEREST INVESTIGATION AND INTERIM REPORT

The Commission issued its Public Interest Investigation and Interim Report into this matter to the RCMP Commissioner and the Minister of Public Safety on November 4, 2010 (**Schedule 1**), in which it made 28 findings and 5 recommendations for change.

Overall, the Commission identified a number of shortfalls both in the conduct of the attending members, and with respect to later actions or lack thereof taken by senior members. The Commission determined that while the force used to effect Mr. Willey's arrest was reasonable in the circumstances, there was an inappropriate use of force during his removal and transport at the detachment, including the simultaneous use of two CEWs and the pointing of a firearm. The Commission found that the members who handled Mr. Willey at the detachment failed to treat him with the level of decency to be expected from police officers.

The Commission also found that members failed to obtain medical assistance for Mr. Willey in a timely manner and failed to communicate all relevant information about Mr. Willey and his arrest to the ambulance attendants.

The Commission determined that following the death of Mr. Willey, the RCMP's North District Major Crime Unit was deployed in a timely manner and in accordance with RCMP policy. However, the Commission found that the scene of the arrest was not properly secured prior to the arrival of the investigative team, that the police vehicle used to transport Mr. Willey was not examined before it was cleaned, that a member's footwear should have been collected as evidence, and that the investigative team failed to recognize that a piece of evidence (Mr. Willey's cell phone) had been lost.

The Commission also found that investigators failed to obtain at least preliminary accounts from the involved members in a timely manner and failed to adequately question them with respect to their use of force. Ultimately, neither the criminal nor conduct aspects of the police involvement in Mr. Willey's death were adequately investigated or addressed.

With respect to the video evidence, the Commission found, through use of an independent forensic expert, that the videotapes provided by the RCMP were the original videotapes depicting Mr. Willey's detention at the detachment and that the frozen video image which would have otherwise shown Mr. Willey's removal from the police vehicle was a result of the video recording system, and not the result of human interference.

THE RCMP COMMISSIONER'S NOTICE

Pursuant to subsection 45.46(2) of the RCMP Act, the RCMP Commissioner is required to provide written notification of any further action that has been or will be taken in light of the findings and recommendations contained in the Interim Report.

On January 5, 2012, the Commission received the RCMP Commissioner's Notice (**Schedule 2**). The Commissioner essentially agreed with all of the Commission's findings. However, while he agreed with the Commission's finding that the use of OC spray during Mr. Willey's arrest was not unreasonable, he did not agree with the Commission's finding that its use was ill-advised. While not discounting the risk of cross-contamination, the Commission, having re-examined its finding in light of the Commissioner's comments, has determined that the appropriate standard to be applied in this instance is one of reasonableness, and has amended the related finding accordingly.

The Commissioner also addressed the Commission's recommendations, agreeing with all in principle. The Commissioner indicated that the recommendations have either since been implemented or will be implemented.

With respect to the Commission's recommendation that the RCMP clarify the roles of the investigative and reviewing parties to ensure that both the criminal and conduct aspects of an investigation are adequately addressed, the Commissioner indicated that this was done through its External Investigation or Review Policy, introduced in 2010. I also note that there is a directive with respect to the requirement to advise senior officials of all serious incidents from a potential Code of Conduct perspective. However, it appears that there may still be a gap between what would be a criminal investigation and a Code of Conduct investigation. The Commissioner should ensure that the RCMP's policies and directives provide clear guidelines with respect to the review of all conduct following a serious incident, and particularly with respect to conduct to be measured against policy and training that may not meet the threshold for a Code of Conduct investigation but, nonetheless, should be reviewed.

I note that the Commissioner also acknowledged that any of the involved members who appeared to have engaged in misconduct cannot be the subject of a formal disciplinary process due to the limitation period under the RCMP Act. However, he stated that he has the option of directing that other formal steps be taken to identify areas where the members' conduct fell short and to take remedial action to address any deficiencies, which he indicated he would do.

I also note that despite the RCMP having put policies in place that generally address the Commission's concerns, the RCMP took nearly 14 months to issue its response to the Commission's Interim Report. In my view, this delay was neither appropriate nor necessary, nor has it been explained. While the Commission is reassured that action has been taken to address the concerns raised in its report, the delay in communicating a response does little to instill trust in the public complaint process or support for the RCMP in general.

THE COMMISSION'S FINDINGS AND RECOMMENDATIONS

As a result of the Commission's investigation, I made a number of findings and recommendations that I believed would assist the RCMP in reviewing and amending policies and enhancing its training to ensure that a similar situation does not occur. The RCMP responded to these findings and recommendations, as outlined above. I reiterate the Commission's findings and recommendations.

Findings

FINDING: The members entered into their interactions with Mr. Willey lawfully and were duty-bound to do so.

FINDING: The force used by constables Graham and Rutten to arrest and apply handcuffs to Mr. Willey was reasonable in the circumstances.

FINDING: Constable Rutten's use of OC spray during the struggle with Mr. Willey at the parkade was not unreasonable in the circumstances.

FINDINGS

- **It was reasonable for Constable Graham to apply the hog-tie in the circumstances despite its use having been discontinued by the RCMP.**
- **The RCMP failed to implement its change in policy with respect to the discontinued use of the hog-tie and approved use of the RIPP Hobble in a timely manner.**

FINDING: Constables Graham, Fowler and Rutten utilized an appropriate level of force when effecting the arrest of Clay Willey on July 21, 2003.

FINDING: Constables Scott and Edinger failed to secure their firearms upon arrival at the detachment as required by RCMP policy and were not justified in deviating from that policy.

FINDING: It was not an appropriate use of force for Constable Scott to have her firearm drawn at the time of Mr. Willey's removal from the police vehicle.

FINDING: Constables Caston and O'Donnell failed to treat Mr. Willey with the level of decency to be expected from police officers when they removed him from the police vehicle and transported him to the elevator.

FINDING: The simultaneous use of the CEW by constables Caston and O'Donnell was unreasonable, unnecessary and excessive in the circumstances.

FINDING: Constables Caston and O'Donnell failed to adequately document their use of the CEW and in a timely manner.

FINDING: Constable Graham failed to obtain medical assistance for Mr. Willey in a timely manner. Having reasonably concluded that it was a safety issue to bring Mr. Willey to the hospital, it would have been more appropriate for Constable Graham to have arranged for an ambulance to meet the members and Mr. Willey at the Prince George RCMP Detachment.

FINDING: The RCMP failed to communicate all relevant information about Mr. Willey and his arrest to the ambulance attendants.

FINDING: The Major Crime Unit was deployed to investigate Mr. Willey's arrest and subsequent death in a timely manner and in accordance with RCMP policy.

FINDING: None of the members of the investigative team had a substantial connection to the members involved in this incident.

FINDING: The scene of Mr. Willey's arrest was not properly secured prior to the arrival of the North District MCU investigation team.

FINDING: Members of the Forensic Identification Section attended and processed the scene of the arrest in a timely manner.

FINDING: The MCU investigative team erred in not having the police vehicle used to transport Mr. Willey examined prior to being cleaned.

FINDING: The MCU investigative team should have collected Constable Rutten's footwear as potential evidence.

FINDING: The MCU investigative team failed to recognize that a piece of evidence (Mr. Willey's cell phone) had been lost.

FINDING: All of the relevant witnesses were located and interviewed in a timely manner.

FINDING: The investigators failed to obtain at least preliminary accounts from the involved members in a timely manner.

FINDING: The MCU investigators failed to adequately question the members involved in this incident with respect to their use of force.

FINDING: An expert on use of force should have been identified earlier on during the investigation and a report prepared, the opinion considered by investigators and then forwarded to Crown counsel.

FINDING: Neither the criminal nor conduct aspects of the police involvement in Mr. Willey's death were adequately investigated or addressed.

FINDING: There was no unreasonable delay in the RCMP's investigation of Mr. Willey's death and it was completed in a timely manner.

FINDING: The videotapes provided by the RCMP to the Commission were the original videotapes depicting Mr. Willey's detention at the detachment.

FINDING: The frozen video image which would have otherwise shown Mr. Willey's removal from the police vehicle was a result of the video recording system, and not the result of human interference.

Recommendations

RECOMMENDATION: The Commission reiterates its recommendation in its report respecting deaths in RCMP custody proximal to the use of the CEW (July 2010) that "the RCMP develop and communicate to members clear protocols on the use of restraints and the prohibition of the hog-tie, modified hog-tie and choke-holds."

RECOMMENDATION: The Officer in Charge of the Prince George RCMP Detachment should take steps to ensure that all members are cognizant of the need to provide all relevant information to medical personnel.

RECOMMENDATION: Where the RCMP investigates itself in situations where force is used and the subject suffers a serious injury or dies, a use of force report should be required prior to review by Crown counsel.

RECOMMENDATION: The RCMP should clarify the roles of the investigative and reviewing parties to ensure that both the criminal and conduct aspects of an investigation are adequately addressed.

RECOMMENDATION: The RCMP should take steps to ensure that any video footage is made available in its entirety and in a viewable format to the coroner's office in the case of an in-custody death and is retained as part of the investigation record.

Pursuant to subsection 45.46(3) of the RCMP Act, the Commission's mandate in this matter is ended.

Ian McPhail, Q.C.
Interim Chair

Commission for Public Complaints Against the RCMP
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SCHEDULE 1

COMMISSION'S REPORT INCLUDING
FINDINGS & RECOMMENDATIONS
(INTERIM REPORT)

SCHEDULE 1

COMMISSION FOR PUBLIC COMPLAINTS AGAINST THE RCMP

CHAIR'S PUBLIC INTEREST INVESTIGATION RE IN-CUSTODY DEATH OF CLAY WILLEY

Royal Canadian Mounted Police Act
Subsections 45.37(1) and 45.43(1)

File No.: PC-2009-3397

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APPENDICES

INTRODUCTION

On July 21, 2003, Mr. Clay Alvin Willey was arrested by members of the Prince George, British Columbia, RCMP Detachment. Shortly after being taken to the detachment, a decision was made to transport Mr. Willey to the hospital. Mr. Willey went into cardiac arrest in the ambulance and died the following morning. The death of a person following an intervention by police often raises questions from the public about the use of force involved, the training of officers, the appropriateness of the police investigating the police and the expected level of transparency of authorities.

In recognition of the concerns expressed about the use of force by RCMP members, the Commission for Public Complaints Against the RCMP (the Commission) will on occasion exercise its authority on behalf of the public, to examine in depth the facts that give rise to the public's concern as well as the adequacy of the RCMP's investigation of the events in question. This report examines the circumstances of Mr. Willey's arrest and subsequent death. It will focus particularly on the events leading to the altercation with Mr. Willey, the level of force used to subdue him, the actions of the RCMP members involved in the altercation and arrest, the following investigation, its adequacy and timeliness and the RCMP policies and procedures underlying this event.

On January 15, 2009, the then Chair also initiated a complaint into the conduct of those unidentified RCMP members present at, or engaged in, incidents where individuals in the custody of the RCMP died following the use of a conducted energy weapon (CEW), which incidents have taken place anywhere in Canada between January 1, 2001 and January 1, 2009. The arrest and subsequent death of Mr. Willey was also considered in that report, which was provided to the RCMP Commissioner in July 2010.

OVERVIEW[1]

On Monday, July 21, 2003, members of the Prince George RCMP Detachment were sent to the area of 11th Avenue in response to two 911 calls. Four units attended. One of the complainants reported a man with a knife and indicated that this man had threatened his dog. On arrival, officers were directed to the rear alley of the Parkwood Mall in the vicinity of the parkade. There, officers found Clay Alvin Willey.

Mr. Willey was found behaving aggressively toward a mall security guard. He was confronted by officers, but did not respond to their verbal commands. He was not armed. Mr. Willey was taken to the ground and a violent struggle

[1] See **Appendix B** for a list of the primary RCMP members involved in the incident and subsequent investigation.

ensued. It took three officers to subdue Mr. Willey. He apparently demonstrated incredible strength and seemed oblivious to pain control techniques. Officers believed Mr. Willey to be in a drug-induced state. During the arrest he was pepper-sprayed, punched twice and kicked twice before the handcuffs could be applied. Even in handcuffs, the struggle continued, leaving members with the need to bind his legs. The only device available to them was a hog-tie rope, the use of which had been discontinued by the RCMP. The senior member at the scene made the decision, for safety reasons, to apply the hog-tie. A decision was also made to take Mr. Willey to cells rather than to the hospital at that time.

Mr. Willey was then transported to the cell block at the Prince George RCMP Detachment. On arrival, he was dealt with by three officers who had not been involved in the arrest. Mr. Willey was pulled by his feet out of the back seat of a police vehicle. Mr. Willey continued to strain against his bindings. He was dragged face down across the concrete floor and down a hallway to the elevator door. When the three officers filed their written reports, they described their actions as having carried Mr. Willey to the elevator by holding his upper torso up off of the ground; video evidence later revealed that that was not the case.

On arrival at the second floor, Mr. Willey was dragged face down out of the elevator and left on the floor. He continued to strain against his bindings, but remained handcuffed and hog-tied. Officers spoke to Mr. Willey, apparently in an attempt to calm him down and have him stop straining against the handcuffs and hog-tie, as he could not be placed in cells while demonstrating that behaviour. An ambulance was called with the intention of having paramedics administer a sedative. Before the ambulance arrived, two officers simultaneously activated their conducted energy weapons [2] (CEW), and used them on Mr. Willey in the touch stun mode in an effort to reorient him. The CEWs did not have the desired effect and Mr. Willey continued to struggle against his bindings as he lay on the floor.

Shortly thereafter, the ambulance attendants arrived but were unable to sedate Mr. Willey. The decision was made to take Mr. Willey to the hospital. While in transit, he suffered the first of several cardiac arrests. Mr. Willey died the following morning.

[2] The conducted energy weapons used by the RCMP are commonly referred to by the brand name of the models authorized for use by RCMP policy: Taser®, which is manufactured by TASER International.

THE CHAIR-INITIATED COMPLAINT AND PUBLIC INTEREST INVESTIGATION

On January 15, 2009, the Chair of the Commission for Public Complaints Against the RCMP initiated a complaint and a public interest investigation [3] (pursuant to subsections 45.37(1) and 45.43(1) of the *Royal Canadian Mounted Police Act* - RCMP Act) into the conduct of those unidentified RCMP members present at, or engaged in, incidents where individuals in the custody of the RCMP died following the use of a conducted energy weapon (CEW), which incidents have taken place anywhere in Canada between January 1, 2001 and January 1, 2009.

The arrest and subsequent death of Mr. Clayton Alvin Willey in Prince George, British Columbia, on July 22, 2003 is one of the incidents covered by that complaint. The original complaint was initiated to examine:

1. whether the RCMP officers involved in the aforementioned events, from the moment of initial contact with the individual until the time of each individual's death, complied with all appropriate training, policies, procedures, guidelines and statutory requirements relating to the use of force; and

2. whether existing RCMP policies, procedures and guidelines applicable to such incidents are adequate.

Mr. Willey's death was the subject of a coroner's inquest conducted by the British Columbia Coroner's Service in October 2004. One of the pieces of evidence considered at the coroner's inquest was a compilation of video footage from a number of security cameras located throughout the Prince George RCMP Detachment. Subsequent to the launch of the Chair's complaint and public interest investigation, the Solicitor General of British Columbia, on behalf of the residents of British Columbia, raised concerns directly with the Chair regarding this incident and in particular with respect to the integrity of the video evidence relating to the arrest and detention of Mr. Willey.

In correspondence to the Commission, [4] the Solicitor General commented that members of the media have "raised concerns with the in-custody treatment of Mr. Willey and have expressed concern that the video in question has not been released to the public. Allegations have also been made in the media that further video evidence exists beyond that contained in the compilation video." Consequently, the Solicitor General requested that the Commission "review the circumstances surrounding the death of Mr. Willey so that British Columbians can have continued confidence in the RCMP."

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[3] See **Appendix C** to view the complaint, titled *Chair-Initiated Complaint & Public Interest Investigation – In-Custody Deaths Proximal to CEW Use*.
[4] See **Appendix D** to view a copy of the correspondence from the Solicitor General.

As such and without limiting the generality of the foregoing, the Chair expanded the public complaint and public interest investigation[5] to examine:

3. whether the RCMP members involved in the investigation of Mr. Willey's arrest and subsequent death conducted an investigation that was adequate, and free of actual or perceived conflict of interest; and

4. whether any other video evidence (other than the compilation video referred to above) exists and whether any RCMP member concealed, tampered with or otherwise inappropriately modified in any way, any evidence, in particular any video evidence, relating to the arrest of Mr. Willey.

Pursuant to subsection 45.43(3) of the RCMP Act, I am required to prepare a written report setting out my findings and recommendations with respect to the complaint. This report constitutes my investigation into the issues raised in the complaint, and the associated findings and recommendations. A summary of my findings and recommendations can be found in **Appendix A**.

COMMISSION'S REVIEW OF THE FACTS SURROUNDING THE EVENTS

It is important to note that the Commission for Public Complaints Against the RCMP is an agency of the federal government, distinct and independent from the RCMP. When conducting a public interest investigation, the Commission does not act as an advocate either for the complainant or for RCMP members. As Chair of the Commission, my role is to reach conclusions after an objective examination of the evidence and, where judged appropriate, to make recommendations that focus on steps that the RCMP can take to improve or correct conduct by RCMP members. In addition, one of the primary objectives of the Commission is to ensure the impartiality and integrity of RCMP investigations involving its members.

My findings, as detailed below, are based on a careful examination of the extensive investigation materials, the RCMP's criminal investigation report, and the applicable law and RCMP policy. It is important to note that the findings and recommendations made by the Commission are not criminal in nature, nor are they intended to convey any aspect of criminal culpability. A public complaint involving the use of force is part of the quasi-judicial process, which weighs evidence on a balance of probabilities. Although some terms used in this report may concurrently be used in the criminal context, such language is not intended

[5] See **Appendix E** to view the complaint, titled *Amendment to Chair-Initiated Complaint & Public Interest Investigation – In-Custody Deaths Proximal to CEW Use*.

to include any of the requirements of the criminal law with respect to guilt, innocence or the standard of proof.

A coroner's inquest into the death of Mr. Willey was held in Prince George, British Columbia, in October 2004. The purpose of such an inquest is to ascertain how, when, where and by what means the deceased died. Although the mandate of an inquest is quite limited, I considered the evidence heard to be an important part of the fact-finding process related to Mr. Willey's death. It is for this reason that the Commission has reviewed all of the testimony given during the inquest.

It should be noted that the RCMP's "E" Division provided complete cooperation to the Commission throughout the Chair-initiated complaint and public interest investigation process. In addition, the RCMP provided the Commission with unfettered access to all materials contained in the original investigative file and all materials identified as part of the public interest investigation. Unless otherwise noted, the members named in this report are referred to by their rank at the time this incident occurred.

FIRST ISSUE: Whether the RCMP officers involved in the aforementioned events, from the moment of initial contact with Mr. Willey until the time of his death, complied with all appropriate training, policies, procedures, guidelines and statutory requirements relating to the use of force, and whether existing policies, procedures and guidelines are adequate.

The events of July 21, 2003

The following account of events flows from witness statements provided during the initial police investigation. I put these facts forward, as they are either undisputed or because, on the preponderance of evidence, I accept them as a reliable version of what transpired.

a. The 911 Calls

On Monday, July 21, 2003, shortly after 5 p.m., the Prince George RCMP Detachment began to receive calls about a man causing a disturbance in the vicinity of 11th Avenue. It was initially reported to police that the man was acting erratically and had threatened a dog with a knife. Several witnesses reported seeing a man, later identified as Clay Alvin Willey, in a neighbourhood located near the Parkwood Mall.

A resident of 11th Avenue was riding his bicycle home when he saw Mr. Willey running "at a full gallop" along the roadway as though he was being pursued. He described Mr. Willey as "moaning and groaning and flailing his arms". The resident saw Mr. Willey suddenly drop to his knees and look under a parked vehicle, and then jump to his feet and run across the street. He described Mr. Willey as being "very distressed."

At about the same time, another resident of 11th Avenue was in her front yard with one of her children. She first noticed Mr. Willey blocking traffic by lying on the roadway. Initially, she thought it was a "drunk" from the Bus Depot and sent her son inside the house. By the man's conduct, she recognized that "there was obviously something wrong with him." She reported that she saw Mr. Willey run as fast as he possibly could through a grouping of trees and run headlong into a fence. Mr. Willey came flying out backwards and landed on the ground. At that point, she recognized the man as being Clay Willey. She last saw him running down 11th Avenue towards Winnipeg Street.

A third resident of 11th Avenue made a phone call to 911 at the request of her boyfriend. According to the transcript of the 911 call, she reported the following:

> There is a gentleman in front of my place turning around, rolling around on the grass. He's broken my neighbour's tree. We're not sure if he's under the influence of drugs or alcohol, but he's not in his right mind.

Two minutes later, at approximately 5: 14 p.m., a second 911 call was received from Mr. Neil Fawcett, who resided on the south side of 11th Avenue, backing onto Parkwood Mall. Mr. Fawcett reported that he had returned home from work shortly after 5 p.m. On arrival, he heard his dogs barking in his rear yard. When he went out to his rear yard, he saw Mr. Willey in the next-door neighbour's yard. Mr. Fawcett reported seeing Mr. Willey making repeated runs at the neighbour's cherry tree in an apparent attempt to climb the tree. In a statement to police shortly after the incident, Mr. Fawcett reported that he saw Mr. Willey "holding his head and rolling, standing up, laying down, standing up, laying down, rolling around, holding the back of his head."

Mr. Fawcett's first impression was that Mr. Willey was suffering a seizure akin to an epileptic fit. Mr. Fawcett reported that Mr. Willey "charged the fence" and pulled something out of his pocket that Mr. Fawcett took to be a knife. (That object was later identified as a cell phone.)

Mr. Fawcett was concerned that, because of the barking of the dogs, Mr. Willey was intent on attacking them. Mr. Willey came over the fence into Mr. Fawcett's yard. After crossing the fence, Mr. Willey took hold of the top rail of the fence and tore it off. At that point, Mr. Fawcett stepped between Mr. Willey and the dogs. Mr. Fawcett could see a red mark on the back of Mr. Willey's head and thought that perhaps he had received a blow to the head. Mr. Fawcett went into his house to call 911.

Mr. Fawcett reported that Mr. Willey never spoke coherently until he picked up one of the dogs and remarked that he loved dogs. That was the only comment

Mr. Fawcett could understand and it was recorded as part of the 911 conversation.

Patrol officers were dispatched to 11th Avenue at 17:16:50 hours. According to the transcript of the Communications Centre tape, responding officers were provided with the following information:

> […] do I have anyone available for a disturbance, we have a Caucasian male in his twenties, he's wearing a blue football jersey with the words "BRADY" on the back, he's outside of 1688 - 11th Avenue, running around rolling on the lawn, he's damaged a neighbour's tree and now he is outside of 1775 - 11th Avenue and he has a knife, he's threatening a dog.

Constable John Graham in Unit 13B1, Constable Holly Fowler in Unit 13B16, Constable Kevin Rutten in Unit 13B13 and Constable Lisa MacKenzie in Unit 13B6 all responded to the call.

b. The RCMP's Initial Response

The first officers on scene went to the residence of the first 911 caller. They were advised that Mr. Willey was not there. They next went to Mr. Fawcett's residence. Constables Rutten and Graham accompanied Mr. Fawcett into his backyard. Mr. Fawcett explained the situation to Constable Rutten and told him that the man had dropped the knife and fled. Constable Graham overheard the conversation and looked to where Mr. Fawcett had pointed. Constable Graham reported that he saw a cell phone on the ground, not a knife. By that point, Mr. Willey was gone and a neighbour, seeing the police officers in the back yard, called to them to say that Mr. Willey had gone into the parkade. Constable Graham used his radio to transmit that information to other responding officers. He then went back to his police cruiser and drove to the entrance to the parkade.

Once inside the parkade, Mr. Willey was heard banging on the window of a vehicle parked there. Brian Chadwick, a security guard working for the Parkwood Mall, reported that he was working in his office when he heard a noise that caught his attention. He left his office to investigate and noticed Mr. Willey lying on his back on the ground in the parkade. Mr. Chadwick described Mr. Willey as holding his head and rolling around on the ground. Mr. Chadwick reported that Mr. Willey was wearing only one shoe at that point and had blood underneath his nose and on the right side of his head. Mr. Chadwick approached Mr. Willey and asked what he was doing. Mr. Willey then jumped up and lunged at Mr. Chadwick. Mr. Chadwick backed away and was in the process of dialling 911 on his cell phone when Constable Holly Fowler (now Corporal Holly Hearn) arrived on scene in a marked police cruiser.

Constable Fowler parked her cruiser at the entrance to the parkade and got out of her vehicle at approximately 5:20 p.m. She was in full police uniform. Upon her arrival, Constable Fowler saw Mr. Willey and Mr. Chadwick in the parkade.

c. The Arrest and Use of Force

Constable Fowler saw Mr. Willey, whom she had known for some twenty years, move towards Mr. Chadwick in what she described as a threatening manner. Mr. Willey fell back to the ground. He then began rolling on the ground, kicking his legs and swinging his arms. After only a few seconds, Mr. Willey got to his feet and began walking towards Constable Fowler. She yelled, "Clay get down on the ground, get down," but Mr. Willey continued moving towards her. She interpreted his actions as a threat towards her and drew her oleoresin capsicum (OC) spray (commonly known as pepper spray). As Mr. Willey advanced towards her, Constable Fowler began backing up to try and maintain a safe distance between them. However, Mr. Willey walked faster towards her.

At this point, Constable Fowler noticed that Mr. Willey was bleeding from the mouth. The injury appeared to be fresh. Constable Fowler repeated her instructions to Mr. Willey but he did not respond to her commands and continued to advance. Her initial assessment of Mr. Willey led her to believe that he was on drugs. With his history of drug abuse and the information that he may have been in possession of a knife, Constable Fowler formed the opinion that Mr. Willey posed a threat to both her and the security guard. She intended to use her OC spray against him when Constable Graham ran up beside her.

As Constable Graham approached, he noticed that Mr. Willey had blood coming from his mouth as well as a "foamy substance on his lips." Constable Graham, who is senior in service to Constable Fowler, took command of the situation and intended to arrest Mr. Willey for causing a disturbance. As he ran up to the right of Constable Fowler, Constable Graham noted that he was able to see Mr. Willey's left hand, which was clenched in a fist. Constable Graham could not see Mr. Willey's right hand. At that point, Mr. Willey was unresponsive to the commands issued by Constable Fowler. Constable Graham, concerned by the possibility that Mr. Willey may have a knife, drew his service pistol and pointed it at Mr. Willey while commanding him to show his hands.

Constable Graham was finally able to see both of Mr. Willey's hands and determined that he did not have a weapon in either, so he holstered his pistol. He directed Mr. Willey to get down on the ground, but Mr. Willey was unresponsive and continued to advance. Constable Graham described Mr. Willey's behaviour as "combative" and knew he could have resorted to OC spray or his baton to control Mr. Willey. However, Constable Graham decided against either of those options because he believed he was physically capable of controlling Mr. Willey. Constable Graham then took hold of Mr. Willey's left arm in an arm bar hold and forced Mr. Willey to the ground. As Constable Graham

later explained, he had to use a "great deal" of force to take down Mr. Willey. Once he was on the ground, Mr. Willey began kicking his legs. Constable Graham attempted to control Mr. Willey's left arm by using a wrist lock. However, Constable Graham was surprised by the strength demonstrated by Mr. Willey, who was able to pull his left arm free. Constable Graham described the strength of Mr. Willey as "superhuman."

Constable Rutten had followed Constable Graham from the residence of Neil Fawcett and parked his police vehicle in the vicinity of the other cruisers near the entrance to the parkade. He exited his vehicle and came to the assistance of Constable Graham who was already on the ground struggling to control Mr. Willey. Constable Rutten believed Mr. Willey to be in a rage or "high on some sort of drug." Constable Graham reported that he knew Mr. Willey had a history of intravenous drug abuse and, because of the presence of blood and bodily fluids, Constable Graham was concerned for his personal safety and that of the officers assisting him.

Constable Rutten took hold of Mr. Willey's right arm in an attempt to force it behind his back so that handcuffs could be applied. Mr. Willey resisted those efforts and attempted to pull his arms free from the grasp of the officers. Constable Rutten was also surprised by the strength demonstrated by Mr. Willey and by the fact that Mr. Willey gave no indication of tiring during the struggle. Constable Rutten managed to apply a handcuff to one of Mr. Willey's wrists, but was unable to force Mr. Willey's arm behind his back so that his other wrist could be handcuffed. Constable Rutten issued commands to Mr. Willey to stop resisting, but the struggle continued.

Constable Rutten reported that he was concerned that he was going to lose his grip on Mr. Willey's arm. That would have turned the handcuff around Mr. Willey's wrist into a weapon if he swung it at the officers. Constable Rutten reported that he therefore felt he needed to escalate the level of force he was using. Constable Rutten maintained control of Mr. Willey's arm and kicked Mr. Willey twice; landing blows in the area of Mr. Willey's upper chest. This use of force produced no change in the resistance offered by Mr. Willey.

When the kicks produced no change in behaviour on the part of Mr. Willey, Constable Rutten then resorted to his OC spray. Constable Rutten reported that he sprayed approximately one quarter canister of OC spray directly into the centre of Mr. Willey's face from a distance of about twelve inches. As the OC spray did not have the desired effect on Mr. Willey, there was no noticeable change in the resistance offered by him.

Constable Fowler, operating under instruction from Constable Graham, also assisted in attempting to apply the handcuffs to Mr. Willey. Mr. Willey demonstrated remarkable strength in rising onto his knees despite being held by the police officers. Constable Graham considered and discounted the use of OC

spray because of cross-contamination concerns. He discounted using his baton because he was afraid Mr. Willey could take it from him and he would be forced to resort to using his firearm. Yet, Constable Graham felt it was necessary to escalate the amount of force used to overcome the resistance. Constable Graham reported that he directed two punches at the lower abdomen of Mr. Willey. There was no change in the resistance offered by Mr. Willey.

After continuing the struggle for a few moments more, Constable Rutten was able to get Mr. Willey's arm behind his back and a second handcuff was applied to secure his arms together. At 5:23 p.m. Constable Rutten notified dispatch that they had Mr. Willey in custody. But even with Mr. Willey handcuffed, the officers reported that the struggle was not over. They continued to have difficulties controlling Mr. Willey. Mr. Willey was still kicking his legs and trying to roll over. Mr. Willey was bleeding from an injury to his mouth and officers feared him biting, spitting or kicking them.

Several independent witnesses reported seeing the struggle to take Mr. Willey into custody and came forward. Some were called to give evidence at the coroner's inquest. One witness who saw the arrest testified as follows:

> I saw two or three officers struggling with Mr. Willey. And my first impression it was a very violent scene, and I was at first shocked at how much force was being used, but as I watched he was so wild, he was so resistant and out of control. There were three officers there and I – my thought was I don't think three is gonna be enough.

She made similar comments in her statements to police during the investigation. Other witnesses confirm Mr. Willey's continued struggle with the police as they tried to handcuff him.

After the handcuffs were placed on Mr. Willey, Constable Graham asked that a paddy wagon be called to the scene. Unfortunately, although that vehicle would have been preferable given its design, it was not available to provide immediate assistance to officers at the scene. Constable Graham then made the decision to apply the hog-tie.[6] He knew that the rope was in the glove box of his cruiser and he had been trained in the technique at the RCMP Training Academy. As he later reported, the hog-tie was the only thing he had available to satisfy the need to further restrain Mr. Willey. Constable Graham felt he had no other option available to him.

Constable Fowler retrieved the rope from Constable Graham's glove box. Once Mr. Willey's feet were secured, the officers were able to get off of him and hoped

[6] The hog-tie involves placing the suspect on his stomach with his hands secured by handcuffs, and legs held together with restraints. The hand and leg restraints are then connected.

that he would now calm down. But, as Constable Fowler reported, Mr. Willey continued to squirm and "was trying to free himself".

Constable Glen Caston was operating a marked police Suburban vehicle, which had bars installed on the side windows in the passenger compartment. In response to radio transmissions calling for the paddy wagon, Constable Caston offered to assist. Constable Caston responded to the scene Code 3 (emergency/lights and sirens) and arrived at 5:26 p.m. He observed Mr. Willey lying on his stomach on the ground; there was some blood on the pavement. Constable Caston noted that there did not appear to be any blood flowing, but he did see blood on Mr. Willey's face around the area of his mouth. Constables Caston and Graham lifted Mr. Willey into the rear compartment of the police vehicle through the passenger side. Constable Rutten reached in through the opposite door and assisted by pulling Mr. Willey along the seat into the vehicle. As Constable Caston recorded in his report, he was trained and worked with a Level 3 Industrial First Aid certificate for several years. He recognized the need to ensure that Mr. Willey was in the "recovery position," meaning that his ability to breathe was unobstructed. Constable Caston positioned Mr. Willey accordingly.

Constable Caston reported that at that point there was a discussion about where Mr. Willey ought to be taken—to the hospital or the cell block. Constable Caston observed that it was not normal practice to take a violent person to the hospital. Constable Graham made the decision that Mr. Willey would be taken to the cell block. As he later reported, he decided not to take him to the hospital because at the time the Prince George Regional Hospital had no place for someone in that state. He felt that given the violent behaviour and strength demonstrated by Mr. Willey, taking him to the hospital presented too much risk for the officers, hospital staff and the public.

Once Mr. Willey was safely loaded into the police vehicle, Constable Graham used his radio to advise the dispatcher that no other units were required. He also requested that an officer with a Taser® meet Constable Caston at the cell block. Constable Graham later explained that he made that request because, according to his training at the time, it was permissible to use a CEW on persons who were non-compliant. Given the level of force required to subdue Mr. Willey at the scene, Constable Graham believed that a CEW was "the least" means of force for someone in Mr. Willey's state.

d. Arrival and Treatment at the Detachment

At 5:27 p.m., Constable Caston left the scene transporting Mr. Willey to the detachment. The drive to the detachment took approximately two minutes. At 5:27 p.m., Constable Jana Scott and Constable Kevin O'Donnell arrived at the detachment to assist Constable Caston with Mr. Willey. They were waiting in the security bay when Constable Caston arrived. (Constables Rutten and Graham had both been exposed to the blood and bodily fluids of Mr. Willey and drove to

the hospital to use their facilities to treat any wounds and to wash up. Constable Fowler returned to the detachment.)

The cell block video shows that Constable O'Donnell and Constable Caston both secured their firearms in the lock-up as required by RCMP policy.[7] Both were carrying CEWs. Constable Jana Scott retained her firearm. Constable O'Donnell, who had not been at the scene where the arrest occurred, had apparently determined that Mr. Willey would not be removed from the vehicle unless there was "lethal force over watch" present. Constable Scott remained in the security bay and drew her firearm to provide that "lethal force over watch."

Constable O'Donnell and Constable Caston both put on protective gloves. In the video, Constable O'Donnell can be seen holding a CEW in his left hand from the point where Mr. Willey is removed from the vehicle.

Removal from the Police Vehicle and Transport to Cell Block

At 17:30:42[8] Mr. Willey was removed from the police vehicle via the passenger side door. The best visual perspective of these actions would have been provided by a camera located in the security bay identified in the recording system as 4-03. However, at the moment when Mr. Willey was being removed from the police vehicle, the system stopped recording the video feed from that camera. The failure of the recording system has been the subject of expert review and is dealt with later in this report.

Constable Caston described the removal of Mr. Willey as follows:

> At first attempt, writer reached in and tried to have him sit up, at this [time] WILEY started to struggle again, trying to kick his legs out at writer. WILEY was still restrained and unable to kick but did start to struggle around so that writer could not have him sit up. He was then pulled out of the vehicle by Cst. O'DONNELL and writer. Members were only able to reach his legs and used the tie for his feet to pull him from the car, his eventual fall to the ground outside of the car was as controlled as possible but as he came out of the vehicle, WILEY landed on the ground on his right side and writer believes that he bumped his head and shoulder on the door and door frame area of the vehicle. During this time WILEY was making a noise almost like he was growling at members. Once

[7] RCMP *Operational Manual*, chap. I.2 – Firearms, section E.2.j., 2003.

[8] Until this point in time, this Summary has relied upon time stamps generated by the Operational Communications Centre (OCC) which are used to record the time of the 911 calls, the Dispatch records and the times recorded in Unit Histories. However, the clock of the OCC system was not synchronized with the clock of the video recording system employed in the cell block at the Prince George Detachment. In order to provide continuity, five minutes and thirty seconds have been added to the time stamps displayed on the video recording system commencing with the point of arrival. That time will hereinafter be referred to as 17:29:06.

> outside on the floor beside the truck, members grabbed onto him and pulled him to the elevator, taking him up to the cells area of the detachment.

Constable O'Donnell also described the act of removing Mr. Willey from the vehicle. In his "Will Say," Constable O'Donnell reported that:

> He and Cst. CASTON removed WILLEY from Cst. CASTON's police vehicle;
> WILLEY was handcuffed and hog-tied at this time;
> While removing WILLEY from the police vehicle he observed WILLEY fell [*sic*] approximately three feet from the seat to the prisoner bay floor.

Constable O'Donnell provided further detail in his occurrence report as follows:

> Cst O'Donnell stood to Cst Caston's left as Cst Caston first reached into the back of the police suburban on the passenger side of the vehicle. Cst O'Donnell observed Cst Caston back out of the passenger door area. Cst O'Donnell assisted Cst Caston in removing the prisoner from Cst Caston's suburban. Cst O'Donnell, standing to the left of Cst Caston looked into the passenger area and observed the prisoner was lying with his head towards the passenger side door on the driver's side. Cst O'Donnell, using right hand, reached in and grabbed onto the prisoners feet area. Cst O'Donnell noted that the prisoner was handcuffed as well as hog-tied. Cst O'Donnell, along with Cst Caston, pulled the prisoner out of the passenger area of the suburban in a controlled manner. When the prisoner was pulled out of the suburban Cst O'Donnell observed that the prisoner fell approx 3 feet from the seat to the prisoner bay floor. It appeared that the prisoner briefly glanced off but did not strike hard in any event his shoulder/right side of his head on the bottom of the door frame. The prisoner ended up on his right side on the cellblock bay floor.

Constable Jana Scott, who was providing "lethal force over watch" at the time, described the act of removing Mr. Willey as follows in her Will Say statement:

> She observed WILLEY being removed from Cst. CASTON's police vehicle. He was removed slowly from the vehicle and did not strike his head.

Constable Scott provided additional information in her occurrence report. She wrote:

> -The back door of 13A1 was opened

> -the male was pulled out of the back feet first, his feet hit the ground, followed by his legs, hips, upper torso, and then the side of his face/cheek. The male came out of the back of the vehicle slowly, on the side of his body, and not hard, the male did not strike head down.

The perspective provided by the only camera working in the security bay at the time Mr. Willey was removed shows a view that is obstructed by the police vehicle. The view shows the passenger side door open at 17:30:25. There is then a view of the heads and upper bodies of Constable Caston and Constable O'Donnell as they remove Mr. Willey from the vehicle and move him towards the hallway which leads to the elevator to the cell block. Constable John Edinger was also present in the security bay around this time.

The floor of the security bay is concrete. There is an aluminum threshold at least one inch high at the doorway leading from the security bay to the hallway. The floor in the hallway is covered with a hard, rubberized material. The members do not stop as they travel from the vehicle to the doorway. In their occurrence reports, the members describe the transport of Mr. Willey from the security bay to the elevator as follows:

> Constable Scott – Mr. Willey was "picked up by the shoulders and taken down the hallway to the elevator."
>
> Constable Caston – "Writer recalls that Wiley was pulled to the elevator along the floor with members holding his upper torso off of the ground by his upper arms."
>
> Constable O'Donnell – "Cst O'Donnell assisted in carrying the prisoner to the elevator. Once the elevator door opened up the prisoner was placed face down on the floor of the elevator with his feet closest to the elevator door."
>
> Constable Edinger – " Writer assisted Cst O'DONNELL in moving subject to elevator. Elevator door opened."

However, the detachment video clearly shows that at 17:30:53 Mr. Willey was dragged face down while Constable O'Donnell and Constable Caston held him by his lower legs and not by his upper arms. From this point on, I rely heavily on the detachment video, as it provides a more reliable and objective record of Mr. Willey's treatment than the aforementioned reports.

At 17:31:05, Constable John Edinger can be seen taking hold of the hog-tie near Mr. Willey's ankles to assist in turning Mr. Willey so he can go into the elevator head first. The video shows that as they turn Mr. Willey, his head may have struck the door frame at the elevator door. The video in the elevator shows

Constable O'Donnell with his right foot on Mr. Willey's back during the short ride up to the second floor. Constable O'Donnell can be seen holding his CEW in his left hand. The elevator ride lasted approximately 10 seconds.

At 17:31:32, the elevator arrived on the second floor and Mr. Willey was dragged out by Constable Caston and Constable O'Donnell, face down by his ankles. As Mr. Willey was removed from the elevator, he slides onto a carpet which is then dragged along under him. At 17:31:43, Mr. Willey can be seen on the video lying face down in the booking area on the carpet.

Call for Ambulance

On the ground level, Constable Scott holstered her firearm and waited for the elevator to return to the ground floor. When she arrived in the booking area, she was asked to call an ambulance. At 17:33:03, Constable Scott can be seen on the video using her radio. She contacted the Operational Communications Centre (OCC) and requested that they contact the ambulance service. She asked them to send Advanced Life Support, Code 3, so that Mr. Willey could be sedated, as he was not cooperating. Constables O'Donnell and Caston also noted the reasons for calling the ambulance as for the purpose of sedation as opposed to treating any physical injury.

CEW Deployment

Shortly after they arrived in the booking area, the video shows Constable Caston conducting a search of Mr. Willey. Constable O'Donnell placed his left foot on Mr. Willey's back. At 17:33:14, Constable O'Donnell placed his CEW on Mr. Willey's back. At about the same time, Constable Caston placed his CEW against Mr. Willey's upper right arm. It appears from the video that both members activated their CEWs at roughly the same time. According to their reports, the CEW had no effect on Mr. Willey.

Arrival of Ambulance

According to the time recorded by the BC Ambulance Service, the ambulance arrived at the detachment at 5:36 p.m. The ambulance attendants found Mr. Willey handcuffed on the floor, face down. He was spitting and moaning incomprehensible sounds. He was also reportedly lifting his head and feet up and rocking in a violent manner. At 17:43:32, Mr. Willey was placed on the ambulance gurney in preparation for transport to the hospital. At 17:46:16, Mr. Willey is last seen on the videotape as the ambulance gurney is wheeled out the doorway into a hallway in the detachment. Constables O'Donnell and Caston rode in the ambulance with Mr. Willey. Since the ambulance attendants had assessed Mr. Willey's vital signs as being stable, the ambulance was driving to the hospital Code 1 (i.e. without lights and siren). As the ambulance approached

the Prince George Region al Ho spital, Mr. Willey we nt into cardiac arrest. He died in hospital the following day.

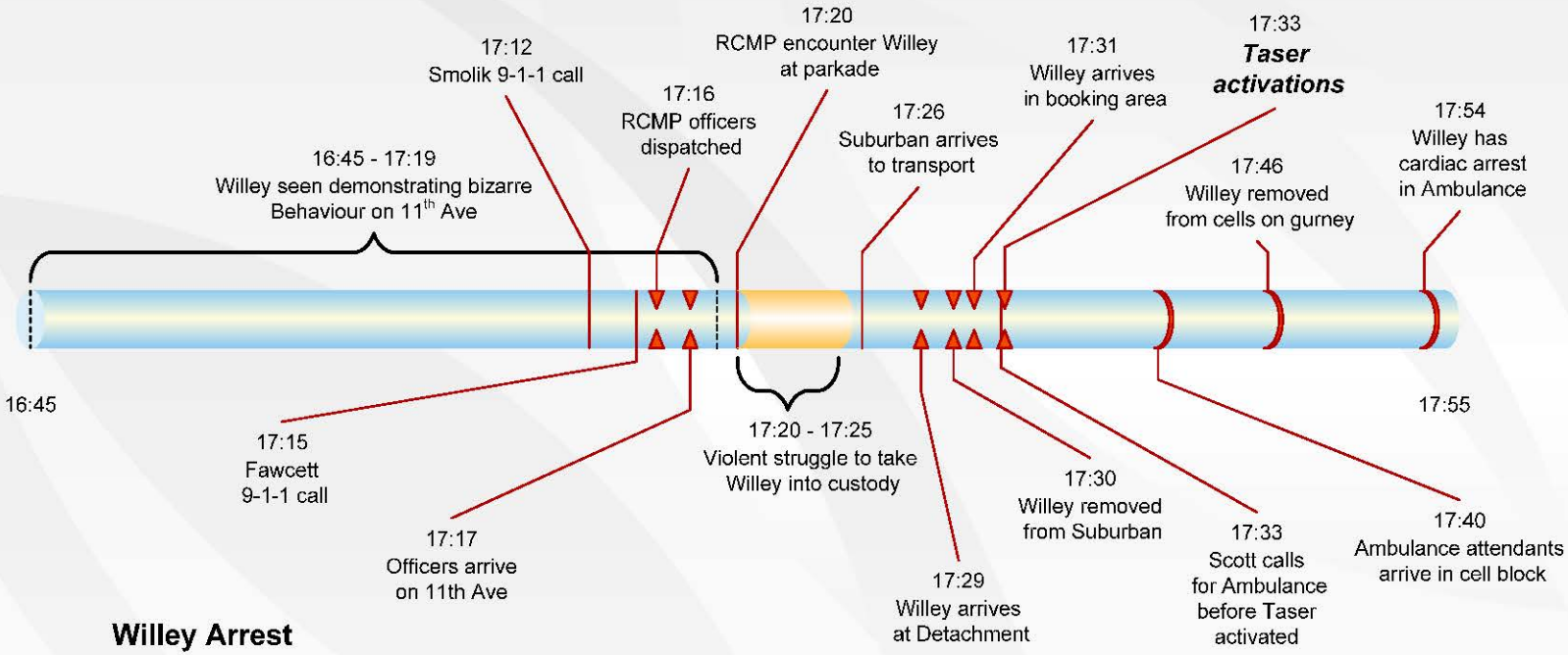
Autopsy of Mr. Willey

Mr. Willey's autopsy was performed by Dr. James McNaughton at the Royal Inland Hospital in Kamloops on July 24, 20 03. Corpo ral G. A. Doll of the Princ e George Forensic Identification Section (FIS) was present at the autopsy. In his report, Dr. McNaughton described the vari ous injuries he noted on the body and offered an opinion that death was due to a "probable coc aine overdose. " Toxicology results lat er confirmed that opinion. Medical records reveal prior occasions where Mr. Willey wa s hospitalized and d iagnosed a s suffering the effects of drug abuse.

Although Mr. Willey sustaine d injuries during h is arrest and deten tion, Dr. McNaughton determined that none of those injuries contributed to his death. During the coroner's inquest in October 2004, Dr. McNaught on testified at length and report ed that in his view, t he Taser® played no role in Mr. Willey's d eath. The coroner's jury found that Mr. Willey's death was due to a cocaine overdose.

Arrest Timeline

Figure 1 (see next page) il lustrates the sequence and timing of events. It is based on a comprehensiv e review of witness statements, 911 and OCC transcripts, Unit Histories, officers' notes and occurrence reports.



Willey Arrest Timeline

Figure 1

ANALYSIS – COMPLIANCE WITH POLICIES, PROCEDURES, GUIDELINES AND STATUTORY REQUIREMENTS

When responding to calls from the public, RCMP members are subject to the duty provisions of the RCMP Act, and in particular paragraph 18(*a*), which states:

> It is the duty of members who are peace officers, subject to the orders of the Commissioner, (*a*) to perform all duties that are assigned to peace officers in relation to the preservation of the peace, the prevention of crime and of offences against the laws of Canada and the laws in force in any province in which they may be employed, and the apprehension of criminals and offenders and others who may be lawfully taken into custody […].

In executing their duties, police officers are guided by policy and are authorized by the *Criminal Code* to use as much force as necessary.[9] However, the officer must be acting on reasonable grounds. Police officers are also justified in using as much force as is reasonably necessary to prevent the commission of an offence for which a person may be arrested without warrant, or that would be likely to cause immediate and serious injury to the person or property of anyone; or to prevent anything being done that he or she believes, on reasonable grounds, would be the commission of such an offence.[10]

In determining whether the amount of force used by the officer was necessary, one must look at the circumstances as they existed at the time the force was used. The courts have been clear that the officer cannot be expected to measure the force used with exactitude.[11]

Police Intervention and Use of Force

At the time that constables Fowler, Graham and Rutten came into contact with Mr. Willey, they were investigating a complaint of bizarre and threatening behaviour. When they first encountered Mr. Willey he was acting aggressively towards a security guard and then towards Constable Fowler. Attempts to speak to him were unfruitful and the officers' commands were ignored by Mr. Willey.

It is clear from the Commission's review of all of the information before it that constables Graham and Fowler were acting in the course of their duty when they started to interact with Mr. Willey. They were investigating a disturbance and found Mr. Willey behaving aggressively. Rather than following the instructions of the members, Mr. Willey continued to advance towards Constable Fowler.

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[9] See section 25 of the *Criminal Code*, reproduced at **Appendix F**.
[10] See section 27 of the *Criminal Code*, reproduced at **Appendix F**.
[11] See, for example, *R. v. Bottrell*, [1981] B.C.J. No. 855 (B.C.C.A.) at para. 16; and *R. v. Nasogaluak*, [2007] A.J. No. 1217 (Alta. C.A.) at para. 22.

Based on all of the information available to constables Graham and Fowler, they had reasonable grounds to believe that Mr. Willey was causing a disturbance contrary to section 175 of the *Criminal Code*. He was intoxicated and interfering with other persons (including disturbing the peace and quiet of residents in the neighbourhood), and the members had a duty to take action. The members reasonably believed that Mr. Willey posed a threat to himself and to others and that it was necessary to arrest him. Such an arrest was justified under section 495 of the *Criminal Code*, as the members had reasonable grounds to believe Mr. Willey would continue that behaviour. As the situation evolved, Mr. Willey became increasingly aggressive and violent. The situation escalated so quickly that none of the members had the opportunity to tell Mr. Willey that he was under arrest.

FINDING: The members entered into their interactions with Mr. Willey lawfully and were duty-bound to do so.

The RCMP has adopted an Incident Management/Intervention Model (IM/IM)[12] that allows for training and supervision of members to ensure compliance with the principles set out in the *Criminal Code* with respect to the use of force. Under the IM/IM, use of force is scalable starting with a verbal request for compliance and increasing use of force to compel compliance up to the use of deadly force. There were seven principles underlying the model that was in place at the time of the incident:

1) The primary objective of any intervention is public safety.
2) Police officer safety is essential to public safety.
3) The intervention model must always be applied in the context of a careful assessment of risk.
4) Risk assessment must take into account: the likelihood and extent of life loss, injury and damage to property.
5) Risk assessment is a continuous process and risk management must evolve as situations change.
6) The best strategy is to utilize the least amount of intervention to manage the risk.
7) The best intervention causes the least amount of harm or damage.

It is incumbent upon the member to perform a risk assessment, first determining which of the five behaviour classifications (cooperative, non-cooperative, resistant, combative and potential to cause grievous bodily harm or death[13]) the subject's actions fall into. Consideration must also be given to the situational factors specific to each incident. These include weather conditions, subject size in relation to the member, presence of weapons, number of subjects and of police, the perceived abilities of the subject (which may include past knowledge of the subject), as well as a host of other incident-specific considerations.

[12] See **Appendix G** for a graphical depiction of the IM/IM.
[13] For an explanation of the categories of resistance, see **Appendix H**.

Intervention Options

The IM/IM sets out various response or intervention options specific to the member's determination of subject behavi our in conjunction with the assessment of the situational factors. Intervention options inclu de officer presence, verbal intervention, empty hand control (soft an d hard), intermediat e devices, impact weapons, lethal force and tactical repositi oning. As diagrammed, i n recognition of the dynamic nature of these in cidents, the IM/IM is not a linear structure such that one response necess arily leads to another. Rather, the IM/IM is intended to train RCMP members with respect to the need to constantly assess the risk and potential for harm and to respond at an appropriate level.

Verbal interventions and tactical repositioni ng occur regardless of the level of risk to assist the member in maint aining cont rol of the situation, de-escalating any confrontation and ensuring maximal safety for all c oncerned. Throughout the management of an incident, a member should be alert to threat cues such as body tension, tone of voice, body position and facial expression to ready them to use an appropriate response option. These threat cues may indicate the potential for a suspect to display more or less re sistant behaviours desc ribed under the categories of resistance that would justify the use of different response options.

Application of Force at the Scene of the Arrest

The statements of constables Graham, Fowl er and Rut ten indicate that they were aware of the follo wing when th ey firs t encountered Mr. Willey: Mr. Willey was acting erratically and possibl y possessed a knife. He was in an open and public place, and was confronting a civili an—the Parkwood Mall security guard. Mr. Willey was we ll k nown to the RCMP in Pr ince George. At the time of this incident, he was 33 years old, meas ured approximately 5'10" and weighed 155 pounds.

Mr. Willey appeared t o have b lood and foa m on his mouth. His eyes were glaze d over, red, and unnat urally wide. He wa s growling lik e a dog and had his hand s clenched into fists. He appeared to be under the influence of drugs. When Mr. Willey was ask ed to ca lm down and to g et on the ground, he was unresponsive. When the members took him to the ground, he resisted and displayed shocking s trength; he was unres ponsive t o pain control. He was a known intravenous drug user, and the members had concer ns for their safety if they came into contact with his bodily fluids.

a) Use of physical force to contain Mr. Willey

Prior to taking Mr. Willey to the ground, Constable Graham approached him with his firearm drawn due to the concern that Mr. Willey had a knife on him. (Although the cell phone was found in the backyard, the members could not ignore the possibility that Mr. Willey may still have a knife.) Constable Graham holstered his weapon when he could see both of Mr. Willey's hands and that they did not contain a knife. As the presence of a weapon supports a reasonable fear of grievous bodily harm or death, I find that Constable Graham's decision to draw his firearm, particularly given the potential danger to a civilian in the area, was reasonable in the circumstances.

After determining that Mr. Willey's hands did not hold weapons, Constable Graham believed that he would be able to take Mr. Willey to the ground using an arm bar technique, which was ultimately successful. The use of an arm bar hold coupled with taking a suspect to the ground are known as soft empty-handed control techniques. They are consistent with the IM/IM and appropriate for use when, as here, verbal interventions have failed.

When Mr. Willey was on the ground, the members managed to attach a handcuff to one arm but had difficulty gaining control of Mr. Willey's other arm. Constable Rutten applied two kicks to Mr. Willey's upper chest area. Constable Rutten felt that he was justified in using kicks to overcome the resistance demonstrated by Mr. Willey. Both of his hands were being used to restrain the arm that was already handcuffed. He was focused on bringing his hand behind his back to secure the handcuffs. Constable Graham stated that he struck Mr. Willey twice in the area of his left side with the intent of having him react in order to free his arm, which Mr. Willey had locked by his side. Strikes and kicks are known as hard empty-handed control techniques. Given Mr. Willey's active resistance to the arrest attempt and his combative behaviour at the time these techniques were applied (he was continually kicking and writhing), I find that such use of force was reasonable in the circumstances.

I note that there were two witness statements that suggested that the RCMP members used additional and unreasonable force against Mr. Willey. Both witnesses knew Mr. Willey. One indicated that after the police vehicle arrived, "that's when Clay really started getting whacked"—he "got the boots instantly." A second witness indicated that there were eight officers attacking one male, four kicking him and standing on his head and four punching him. I find that these statements lack any credibility, as they are wholly inconsistent with every other statement from both civilian and member witnesses.

FINDING: The force used by constables Graham and Rutten to arrest and apply handcuffs to Mr. Willey was reasonable in the circumstances.

b) Use of OC spray[14]

Constable Rutten considered the intervention options open to him in the situation and decided to use OC spray prior to Mr. Willey being handcuffed. He sprayed OC spray directly into the centre of Mr. Willey's face from a distance of about twelve inches. At that point, pain compliance techniques were not working to bring Mr. Willey under control. However, the OC spray also did not produce the desired result, as there was no change in the level of resistance offered by Mr. Willey.

When Constable Graham was interviewed by the Commission's investigator, he stated that he had considered and discounted using OC spray for several reasons. He was concerned that using OC spray in those circumstances posed an unacceptable risk of cross-contamination. He also doubted that OC spray would be effective on a subject in the condition that Mr. Willey was in.

While Constable Rutten's use of OC spray may have been ill-advised given the risk of cross-contamination, I find that he reasonably believed that it could assist in bringing Mr. Willey under control and, consequently, that its use was proportional and reasonable in the circumstances.

FINDING: Constable Rutten's use of OC spray during the struggle with Mr. Willey at the parkade was ill-advised, but not unreasonable in the circumstances.

c) Use of hog-tie

By all reliable reports, even when the handcuffs were applied to restrain Mr. Willey's wrists, the struggle was not over. Constable Graham stated that given Mr. Willey's state, he needed some method of preventing Mr. Willey from kicking or running away.

The hog-tie had been discontinued by the RCMP as of May 2002. A bulletin had been issued by the National Contract Policing Branch after the Operational Policy Group—Community, Contract and Aboriginal Policing Services—concluded that the RIPP Hobble prisoner restraint device was a viable alternative to the hog-tie and was approved for operational use. However, in July 2003 front-line police officers in Prince George had not yet been trained or equipped to use the RIPP Hobble, and the rope used to apply the hog-tie was still carried in RCMP vehicles. At the coroner's inquest in 2004, Constable Graham stated that he was unfamiliar with the RIPP Hobble and had not received any training on it.

Constable Graham reasonably concluded that he needed to secure Mr. Willey's legs. He considered his options and decided to apply a hog-tie. That decision was contrary to existing RCMP policy.[15] However, it is important to note that using

[14] Oleoresin capsicum spray (commonly known as pepper spray).
[15] RCMP *Operational Manual*, chap. III.3 – Prisoners and Mentally Disturbed Persons, section E2.8.

restraints that are not approved pursuant to RCMP policy does not make their use unreasonable per se. I find that Constable Graham's decision to apply a hog-tie was reasonable, as he had no other available options to secure Mr. Willey's legs and reasonably feared that Mr. Willey would get up and continue fighting. Constable Graham's options were limited because the RCMP had failed to implement its policy decision on the RIPP Hobble in a timely fashion.

Given that body position is often listed as an antecedent or contributing cause of death in in-custody death cases, which led to the change in policy, the RCMP ought to ensure that members understand the potential impact of using prohibited restraint mechanisms. As such, the Commission recently recommended in its report respecting deaths in RCMP custody proximal to the use of the CEW (July 2010) that "the RCMP develop and communicate to members clear protocols on the use of restraints and the prohibition of the hog-tie, modified hog-tie and choke-holds." The Commission reiterates that recommendation.

FINDINGS

- **It was reasonable for Constable Graham to apply the hog-tie in the circumstances despite its use having been discontinued by the RCMP.**
- **The RCMP failed to implement its change in policy with respect to the discontinued use of the hog-tie and approved use of the RIPP Hobble in a timely manner.**

RECOMMENDATION: The Commission reiterates its recommendation in its report respecting deaths in RCMP custody proximal to the use of the CEW (July 2010) that "the RCMP develop and communicate to members clear protocols on the use of restraints and the prohibition of the hog-tie, modified hog-tie and choke-holds."

Summary

In my view, it was clear that Mr. Willey was not acting rationally at the time of his arrest and was not capable of understanding the consequences of his actions. Due to his unpredictable and violent behaviour, it was necessary to restrain him by means of physical force. Considering all the available information and taking into account the behaviour displayed by Mr. Willey, I find that constables Graham, Fowler and Rutten had a reasonable fear of physical harm to themselves or others that led them to exercise their use of force options in a manner consistent with the policies of the RCMP and the legal statutes.

FINDING: Constables Graham, Fowler and Rutten utilized an appropriate level of force when effecting the arrest of Clay Willey on July 21, 2003.

Application of Force Following Initial Arrest

Mr. Willey was transported from the scene of the arrest to the Prince George RCMP Detachment cells. Upon arrival, constables Kevin O'Donnell, Glenn Caston, Jana Scott, and John Edinger were present. They were aware that Mr. Willey had been combative and difficult to control during his initial arrest. Upon arrival at the detachment, Mr. Willey continued to strain against his restraints. Mr. Willey was generally non-communicative (other than grunting and making other incoherent noises), and had blood on his head area (although there was no apparent ongoing flow of blood) and a white foam on his mouth. A number of the members confirmed in their statements that they believed Mr. Willey to be on drugs.

a) Removal from police vehicle and transport to cell block

Mr. Willey was removed from the police vehicle shortly after arriving at the Prince George RCMP Detachment. Constable Caston noted in his statement that he and Constable O'Donnell "locked up [their] guns in the bay lockers as per RCMP policy" and proceeded to remove Mr. Willey from the vehicle. Constable Scott indicated that Constable O'Donnell would not take Mr. Willey out of the vehicle without "lethal force over watch," a tactical technique normally used in the field when dealing with an individual who is not restrained. As such, she stayed in the bay area with her firearm out while Mr. Willey was removed from the police vehicle. We have no further explanation as to why the firearms policy was not followed. Constable Edinger stated in an interview with RCMP investigators that he did not secure his firearm, but rather kept it on him, as he sensed urgency when he arrived to assist.

RCMP policy provides that firearms are not to be carried when entering the cell block area or secure bay.[16] However, if a member believes it is warranted to do so, the member must "conduct a risk assessment taking into consideration [his or her] safety, the safety of prisoners and that of other individuals in the immediate area."[17] Lethal force over watch is a tactical technique normally used in the field when dealing with an individual who is not handcuffed and hog-tied. In my view, there was neither an urgency to the removal of Mr. Willey from the police vehicle that prevented Constable Edinger from securing his firearm nor any explanation provided in the statements of constables Scott and O'Donnell that justified a need for lethal force over watch that would otherwise be prohibited by RCMP policy.

According to the law and RCMP policy, a firearm is a permitted use of force only where a member perceives a threat of death or grievous bodily harm. It is a weapon of last resort. The *Criminal Code* only provides protection to police officers who use force that is intended or is likely to cause death or grievous bodily harm if the officer had reasonable grounds to believe that it was necessary to

[16] RCMP *Operational Manual*, chap. I.2 – Firearms, section E.2.j.
[17] RCMP *Operational Manual*, chap. I.2 – Firearms, section E.2.j.1.

protect against same [18]. In my view, Constable Scott having her firearm drawn while Mr. Willey was being removed from the vehicle (handcuffed and hog-tied) was an overreaction and unjustified in the circumstances.

FINDING: Constables Scott and Edinger failed to secure their firearms upon arrival at the detachment as required by RCMP policy and were not justified in deviating from that policy.

FINDING: It was not an appropriate use of force for Constable Scott to have her firearm drawn at the time of Mr. Willey's removal from the police vehicle.

As noted above, Mr. Willey was pulled from the police vehicle by his feet, with no support given to his upper body. I note that neither Constable Caston nor Constable O'Donnell had been at the scene and fought to subdue Mr. Willey. They were trained professionals and had a number of options available to them in removing Mr. Willey. Time was on their side. I note that as he was holding his CEW in one hand, Constable O'Donnell had only his right hand available to assist Constable Caston in removing Mr. Willey from the police vehicle. If they were concerned about the possibility that he would kick and injure them, they could have removed him head first via the driver's side door. They had donned protective clothing and could have used other measures if they were concerned that he might spit blood at them.

Another alternative was to cushion his fall as Mr. Willey slid off the end of the back seat. Or the members could have asked for help, as there were others available in the office nearby who could have assisted. Neither Constable Scott nor Constable Edinger assisted with the removal. Rather, Constables Caston and O'Donnell chose to pull Mr. Willey out feet first, without anyone or anything to break his fall when he came off the end of the back seat. Consequently, Mr. Willey was pulled out and fell, first striking the door frame and then landing on the concrete floor. He did not have his hands available to help break his fall and no one else assisted him. The reason they chose to remove him from the vehicle in that fashion was not canvassed during the investigation and, in my view, their actions were unreasonable.

RCMP Inspector Tom Gray, who conducted the Independent Officer Review (discussed later in this report), recognized that the removal was a potential problem. During an interview with the Commission's investigator, Inspector Gray identified the method used by the members to remove Mr. Willey from the vehicle as "an obvious concern". He indicated that he had thought about the situation but concluded that the members did not intend to hurt Mr. Willey. Concern was also expressed by the regional Crown counsel who reviewed the file, but the decision was made not to lay criminal charges against the members. The RCMP's own use

[18] *Canada Criminal Code*, s.25.

of force expert, Corporal Gregg Gillis, testified at the coroner's inquest that, without an explanation for the method of removal, there was certainly a better way to remove Mr. Willey from the vehicle, which would be to pull him out by hooking their arms under his shoulders to allow for better control of his upper body and head.

Given the treatment Mr. Willey was subjected to as demonstrated by the cell block video, I have no doubt that no additional care was taken when dragging Mr. Willey face down across the elevated aluminum threshold in the doorway that connected the security bay to the hallway to the elevator. As he was dragged through the hallway, the video shows a trail of liquid from his face or mouth being transferred to the floor. Even the members' supervisor, Staff Sergeant John Scott, told the Commission's investigator that it is not generally appropriate to drag a prisoner face down; he said if you have to drag them, it would be more appropriate to turn them around so that their shoulders are on the ground.

The placement of Mr. Willey into the elevator demonstrated no improvement in his treatment. He was again dragged by the feet, face down, and it appears on the video that his head may have hit off the elevator door. No attempts were made to facilitate a more controlled transfer, despite there being four members present.

While I acknowledge that Mr. Willey was a difficult subject due to his constant movement and physical resistance, I find that the members treated him with a level of callousness that was unwarranted. The members owed a duty to care to Mr. Willey while he was in their custody. RCMP policy provides that "a person in RCMP custody will be treated with decency and provided with all the rights accorded to him/her by law."[19] I find that the members failed to treat Mr. Willey with the level of decency to be expected when he was removed from the police vehicle and transported to the elevator.

FINDING: Constables Caston and O'Donnell failed to treat Mr. Willey with the level of decency to be expected from police officers when they removed him from the police vehicle and transported him to the elevator.

b) CEW deployment

Under the *Criminal Code*, the CEW is a prohibited firearm and can only be used by law enforcement officers. The Commission has been steadfast in its position that when used appropriately, the CEW can be an effective tool for the RCMP. The Commission has also maintained that the CEW causes intense pain, it may exacerbate underlying medical conditions, and it has been used in situations where its use is neither justifiable nor in accordance with RCMP policy.

The Commission made a number of recommendations to the RCMP in its report *RCMP Use of the Conducted Energy Weapon (CEW)* in June 2008, its *Report*

[19] RCMP *Operational Manual*, chap. III.3 – Prisoners and Mentally Disturbed Persons, section C.1.

Following a Public Interest Investigation into a Chair-Initiated Complaint Respecting the Death in RCMP Custody of Mr. Robert Dziekanski in December 2009, as well as a number of other reports issued by the Commission since the RCMP began using the CEW. Many of those recommendations have been implemented by the RCMP; some have not.

RCMP policy has consistently recognized the need to assess other means of intervening to calm or subdue a suspect, and has required from the outset (absent an operational situation which would preclude such a step) that members identify themselves as peace officers and issue a warning prior to deploying the CEW. Current RCMP policy recognizes that multiple deployments of the CEW may be hazardous to a subject.

Both Constable Caston and Constable O'Donnell had been certified in the use of the CEW the month prior to their encounter with Mr. Willey, and so were authorized by RCMP policy to use the weapon. They appear to have been of the same mind with respect to the use of the CEW in these circumstances, as they are seen on the cell block video simultaneously using their CEWs in push stun mode.[20] While there has been some dispute as to how many times the CEW was used on Mr. Willey, the video and medical evidence, as well as the statements of the members, indicate that each member activated their CEW only one time.[21]

Constable Caston described his reasons for deploying the CEW as follows:

> During the time that WILEY was in cells, the tazer was used in stun mode to try and get WILEY to settle down. In "stun" mode no projectiles (darts) are used. The idea when using a tazer is to provide a pain stimulus that the person reflects on when they continue the dangerous behavior. The idea is to have the individual focus on the localized pain to try and bring some reality to their thought process. The tazer was used on his right arm once by writer and once on his back by Cst. O'DONNELL. Hopes are that the person responds to the first incident and calms. This was not the case with WILEY, he remained combative.

Constable O'Donnell described his reasons for deploying the CEW as follows:

> For a number of minutes, there were only Cst. O'Donnell and Cst. Caston attempting to control the prisoner. Cst. Scott and Cst.

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[20] The CEW may be deployed in two modes–probe and push stun. Probe mode refers to the discharge of the weapon by firing a cartridge containing probes which lodge in the subject's body and are connected to the CEW by means of electrical wires. Push stun mode refers to the electrodes of the CEW being placed directly against the subject.

[21] I note that the CEW download reports show an additional activation on Constable Caston's CEW six minutes apart from the activation shown on the video. However, the video and medical evidence appears to contradict this report.

> Edinger were also present. Cst. O'Donnell administered the taser one time using the touch stun in attempts to control the prisoner during one of his fits of rage when he was squirming around. In using the touch stun mode of the taser, Cst. O'Donnell was hoping to gain pain compliance and stop the prisoner from squirming around using the minimal amount of force necessary. […] Cst. O'Donnell administered the taser because he didn't want to have to wrestle or go near the prisoner's head due to his bleeding.

At the time of the incident, RCMP policy provided that the "CEW may only be used to subdue individuals suspects who resist arrest, are combative or suicidal."[22] The CEW was characterized "as a less lethal means for controlling suspects and averting injury to members, suspects and the public."[23] The members' justification for its use appears to have been on the basis that Mr. Willey was continuing to resist arrest and there was a risk that if he broke free of his restraints, he would be combative again.

According to the IM/IM, the key consideration in determining whether or not the members' CEW usage was appropriate in the circumstances is the assessment of the subject's behaviour. Whenever a police officer is engaged in an interaction with a member of the public it is incumbent upon that police officer to perform a risk assessment to ensure that his or her response is both reasonable and proportionate to the subject's behaviour. Despite the use of the term "combative" by Constable Caston in his report when referring to Mr. Willey's behaviour, it is clear to the Commission that Mr. Willey's behaviour at the time the CEW was used fell within the resistant category. There was no evidence to indicate that Mr. Willey was striking out at members; rather, he was straining against his restraints, which would constitute active resistance.

RCMP policy at the time specified that the CEW may be used against "suspects who resist arrest." In his testimony at the coroner's inquest, Corporal Gillis explained that while he considered resisting arrest and resistant behaviour to be two different concepts, he believed the use of the term "resisting arrest" in the CEW policy to cover both. I note that Corporal Gillis is very involved in the training of members with respect to the CEW and other uses of force. In my view, this illustrates the lack of clarity in the RCMP's former CEW policy, which was to guide the members at the time of this incident.

The RCMP's current CEW policy provides that a member must only use a CEW in accordance with "the principles of the Incident Management/Intervention Model (IM/IM) and when a subject is causing bodily harm, or the member believes on reasonable grounds, that the subject will imminently cause bodily harm as

[22] RCMP *Operational Manual*, chap. III.2 – Arrest, section I.5.a.4.
[23] RCMP *Operational Manual*, chap. III.2 – Arrest, section I.5.a.1.

determined by the member's assessment of the totality of the circumstances." [24] It is clear to the Commission that the use of the CEW in Mr. Willey's circumstances would not meet the requirements of today's policy, as Mr. Willey was not, at the time of its use, causing bodily harm, nor did the members have reasonable grounds to believe that he would *imminently* cause bodily harm. However, I cannot measure the members' conduct in 2003 against today's policy.

The change in policy reflects the RCMP's recognition that the CEW can cause more pain and potential injury than originally believed and taught to members. As Corporal Gillis stated in his evidence at the coroner's inquest, in 2003 members were taught to use the CEW for pain compliance; however, such actions as kicks and strikes were not recommended due to the likelihood of those actions causing a substantial injury to the subject. It is clear from his testimony, as well as statements from Staff Sergeant John Scott, that the seriousness of using the CEW was not communicated during training and members were taught to use the weapon when a subject was "non-compliant." That training simply does not adequately reflect what is and was required by law and is now reflected in RCMP policy.

While resistant behaviour may sometimes be classified as "non-compliant," it does not always equate to resisting arrest. The members wanted Mr. Willey to stop straining against his restraints; however, the fact remains that he was restrained. In my view, there is a significant difference between using a CEW to gain compliance from a subject in order to apply restraints when they are resisting the physical act of arrest and could potentially escape, and using a CEW to "calm down" a subject once they are already restrained.

I recognize that human responses may not always align exactly with policy, especially when those responses come about in the heat of an incident and reactive decisions are made intuitively without time to fully reflect on potential outcomes. It is for this reason that the training component is crucial to the outcome of an incident. If police officers are not trained to react in a manner that will bring about the most successful and least injurious outcome, the decisions taken in response to demonstrated behaviour will not be in keeping with the principles of the IM/IM and community expectations of the police. The result of such training might well have been that Constables Caston and O'Donnell were more inclined to deploy the CEW because of the position of the RCMP that the CEW is an effective, relatively safe and less harmful means to achieve an end.

That being said, I find it even more unacceptable that the members would use their CEWs simultaneously. That use was neither in accordance with RCMP policy nor a reasonable use of force in the circumstances. As noted in their reports, Constables O'Donnell and Caston's primary purpose in using their CEWs on Mr. Willey was for pain compliance, i.e. to inflict pain in an effort to reorient him and

[24] RCMP *Operational Manual*, chap. 17.7 – Conducted Energy Weapon, section 3.1.1, dated April 29, 2010.

have him comply with instructions not to fight the physical restraints and to calm down. I understand that Constable O'Donnell had some concern that Mr. Willey could break his restraints, and had originally requested a restraint board, which was not available at the Prince George RCMP Detachment. However, while breaking his restraints was a possible outcome, it was not a probable outcome.

In addition, I find it difficult to accept that the breaking of restraints was an overriding concern since just prior to their simultaneous use of the CEW, neither officer used more than one hand (and at times used the same hand that held their CEW) and one leg from a standing position to counter Mr. Willey's pull on the restraints. Nor did they ask any of the nearby members to assist with restraining Mr. Willey while they waited for the arrival of the ambulance. I note that throughout the encounter, both prior to the use of the CEW and after, a number of members were in and out of the area observing what was happening. I also note that Constable Jana Scott is seen on the cell block video to be in the immediate area at the time the members chose to use their CEWs. The RCMP's CEW policy required the members to "consider other possible intervention options to calm or subdue"[25] Mr. Willey. In my view, they failed to do so.

Instead, Constables O'Donnell and Caston decided at the same time to use their CEWs on Mr. Willey without any apparent communication about their intention to do so and despite the fact that there were no urgent circumstances that necessitated the immediate application of the CEW. Constables O'Donnell and Caston failed to make an adequate risk assessment prior to taking such action.

FINDING: The simultaneous use of the CEW by constables Caston and O'Donnell was unreasonable, unnecessary and excessive in the circumstances.

I note that RCMP policy dictates a reporting process for each usage of a CEW. A Conducted Energy Weapon Usage Report was not filed until sometime after the coroner's inquest. The form, which was completed by Staff Sergeant Scott, contains a reference to the findings of the inquest. It was only submitted in relation to Model M-26 Taser serial #010093, which was used by Constable O'Donnell. There is no record of a similar Usage Report filed in relation to the Model M-26 Taser Serial #011406 which was used by Constable Caston, although he is mentioned in the Report.

FINDING: Constables Caston and O'Donnell failed to adequately document their use of the CEW and in a timely manner.

[25] RCMP *Operational Manual*, chap. III.2 – Arrest, section I.5.b.

Obtaining Medical Treatment

The RCMP owes a duty of care to those in its custody, and its policies provide direction to members with respect to obtaining medical treatment for prisoners. At the time of Mr. Willey's arrest, the relevant policy stated, in part:

> If medical sedation is warranted in restraining a person, contact a medical practitioner and ensure supervision.
>
> It is the responsibility of the first member on the scene to complete an assessment of responsiveness. […] If there is any indication that a person is ill, suspected of having alcohol poisoning, a drug overdose, or ingested a combination of alcohol and drugs, concealed drugs internally, or sustained an injury, seek immediate medical attention. [26]

The ambulance was called by Constable Jana Scott on the direction of constables O'Donnell and Caston after they had arrived in the cell block. As noted above, the members all indicated that their intention in having paramedics attend the scene was to sedate Mr. Willey so that he would be adequately restrained and under control; it was not out of concern for any physical injuries that he incurred. The ambulance attendants were not in a position to sedate Mr. Willey, and so he was transported to the hospital. It was in the ambulance that he went into cardiac arrest.

The question remains as to whether the members adequately discharged their duty of care in calling the ambulance when they did. Whether or not Mr. Willey should have been taken from the scene of his arrest directly to the hospital was a significant issue during the coroner's inquest. Constable Graham provided his reasons for making the decision to have Mr. Willey taken to the cell block, which were largely safety concerns. During an interview with the Commission's investigator, Constable Graham stated that "in hindsight" calling the ambulance would have been the better course of action.

At the coroner's inquest, much evidence was given about a series of symptoms displayed by persons who are in a state referred to as "excited delirium," "agitated delirium," or "cocaine psychosis." At the time of this incident, it appears that none of the members were very familiar with such conditions. RCMP policy now provides that, whenever possible, when responding to reports of an individual who is violent or in an acutely agitated or delirious state, members should request the assistance of emergency medical services. If possible, they should bring medical assistance to the scene.[27] An "acutely agitated or delirious" person is defined to include "a person demonstrating one or more symptoms, such as substance abuse coupled with severe mental and physical exhaustion, or hyper-aggressiveness

[26] RCMP *Operational Manual*, chap. III.3 – Prisoners and Mentally Disturbed Persons, section E.2.c. and E.3.a.
[27] RCMP *Operational Manual*, chap. 17.7 – Conducted Energy Weapon, section 3.1.7.

often characterized by extreme agitation, profuse sweating, hostility, exceptional strength and endurance without apparent fatigue."[28] This policy evolved from local and international police in-custody deaths in situations similar to that of Mr. Willey. RCMP members now receive some training on recognizing these symptoms and the need to obtain emergency medical assistance.

It would be unfair to judge the members' decision not to call an ambulance to meet Mr. Willey at the detachment against the current policy. Nonetheless, I find that the condition of Mr. Willey at the time of his arrest was such that medical assistance should have been requested at that time. It is clear from the record that a number of members suspected that Mr. Willey was intoxicated and had consumed illicit drugs, that he was non-communicative, that he had blood on his head and that he had some foam around his mouth. The arrest was so violent that there were substantial bloodstains at the scene. The autopsy photos show a number of abrasions on Mr. Willey's body, likely either caused by his actions prior to encountering the police that day or his arrest. Many of those would have been obvious to the members.

In my view, Mr. Willey had clearly suffered injuries and there was reason to believe that he was either suffering from a drug overdose or had ingested a combination of drugs and alcohol. For all of these reasons, the duty of care owed by police officers to those in their custody and RCMP policy required that the members obtain medical assistance for Mr. Willey immediately upon his arrest.

I find that the members' assessment that it was impractical and potentially dangerous for the public to bring Mr. Willey to the local hospital given his conduct was reasonable in the circumstances. I also find that it would not have necessarily been appropriate to wait at the scene of the arrest for medical personnel, as Mr. Willey presented a danger to the public and needed to be contained. However, I find that having made the decision to bring him to the detachment, the members should have called an ambulance to meet them there to assess Mr. Willey.

FINDING: Constable Graham failed to obtain medical assistance for Mr. Willey in a timely manner. Having reasonably concluded that it was a safety issue to bring Mr. Willey to the hospital, it would have been more appropriate for Constable Graham to have arranged for an ambulance to meet the members and Mr. Willey at the Prince George RCMP Detachment.

I also have some concern about the level of information that was communicated by those involved with Mr. Willey's arrest to the ambulance attendants. RCMP policy provides that members must:

> Provide all relevant information concerning any injury, the results of your enquiries and any observations regarding the

[28] RCMP *Operational Manual*, chap. 17.7 – Conducted Energy Weapon, section 2.1.

> possible substances ingested. Indicate your assessment of the person's responsiveness. Include the nature and degree of any force used to arrest the prisoner.[29]

In his statement to police following the incident, the ambulance attendant indicated that when assessing Mr. Willey's spinal concern, he asked members if Mr. Willey hit his head or anything of that nature. He was told no. (It is not clear from the record who communicated that information.) However, there were various points throughout the incident where Mr. Willey may have hit his head—when he scaled the fence prior to his arrest, when he was taken to the ground, and when he was dragged feet first out of the police vehicle. The RCMP's failure to communicate this information could have compromised Mr. Willey's medical care.

In addition, it does not appear that the ambulance personnel were made aware that Mr. Willey had been pepper-sprayed. RCMP policy requires that the affected areas should be exposed to fresh air, and if possible flushed with cool water.[30] Mr. Willey was continually spitting, which may have been due to the effects of the pepper spray. I accept that it was not practical, given Mr. Willey's behaviour, to flush his eyes and mouth while he was in the cell block. However, at the very least the fact that he had been pepper-sprayed should have been communicated to the ambulance personnel so that Mr. Willey could be decontaminated at the earliest possible opportunity.

FINDING: The RCMP failed to communicate all relevant information about Mr. Willey and his arrest to the ambulance attendants.

RECOMMENDATION: The Officer in Charge of the Prince George RCMP Detachment should take steps to ensure that all members are cognizant of the need to provide all relevant information to medical personnel.

[29] RCMP *Operational Manual*, chap. III.3 – Prisoners and Mentally Disturbed Persons, section E.3.f.1.
[30] RCMP *Operational Manual*, chap. III.2 – Arrest, section I.2.c.

SECOND ISSUE: THE INVESTIGATION – Whether the RCMP members involved in the investigation of Mr. Willey's arrest and subsequent death conducted an investigation that was adequate, and free of actual or perceived conflict of interest.

ANALYSIS – ADEQUACY OF THE INVESTIGATION

When evaluating the adequacy of a criminal investigation, the Commission considers the steps taken during the investigation. RCMP policy is clear that members must follow all leads, and avail themselves of additional resources where required. Obviously, there are limits to the extent of the investigation and this depends on the nature of the offence. The proper investigation of any crime or potential crime requires, in part, that a member:

a) Pursue all leads provided promptly and effectively.
b) Interview all possible sources and suspects promptly and effectively.
c) Request all relevant forensic tests/reports to check for physical evidence and consult with other experts with specialized knowledge.
d) Follow related RCMP policy and reference other related police technical texts as required.
e) Maintain good case management of the file, ensuring that properly written notes support the actions taken during the investigation as well as support any subsequent prosecution.

The main objective of a criminal investigation is to gather enough information to be able to form reasonable grounds to believe that certain persons committed an offence.

Mr. Willey went into cardiac arrest during his transport to the hospital at approximately 5:54 p.m. on July 21, 2003. Sergeant Glenn Krebs (now Staff Sergeant), with the North District Major Crime Unit (MCU), was enlisted to assemble a team to investigate the possible in-custody death at approximately 6:15 p.m. that same day, in accordance with RCMP policy that requires that an "independent" investigation be conducted immediately when someone being arrested or in RCMP custody/care is seriously injured or dies. [31] Staff Sergeant Krebs immediately assembled his team, which arrived at the scene of the arrest by 7:30 p.m.

FINDING: The Major Crime Unit was deployed to investigate Mr. Willey's arrest and subsequent death in a timely manner and in accordance with RCMP policy.

[31] RCMP *Operational Manual*, chap. III.3 – Prisoners and Mentally Disturbed Persons, section D.3.

Major Case Management

When investigating incidents that are deemed to be serious in nature, such as homicides, most Canadian police agencies subscribe to a series of investigative protocols and processes known as Major Case Management (MCM).

MCM is managed by the Major Case Management Team (MCMT) illustrated by the "command triangle," which includes the Team Commander (formerly called Team Leader), the Primary Investigator and the File Coordinator. The Team Commander has ultimate authority, responsibility and accountability for the MCMT, its resources (human and physical) and its mandate. The Primary Investigator controls the overall investigative process. The File Coordinator is responsible for the control, supervision, organization and disclosure of the file documentation.

As noted above, the command triangle roles were assigned to members of the "E" Division North District Major Crime Unit (MCU). Staff Sergeant Krebs assumed the role of Team Commander and assigned Constable Alex Lynch as Primary Investigator and File Coordinator. Corporal Dave Chauhan was appointed as Exhibit Custodian. Constable Sukh Parmar was assigned as an investigator.

In his response to written questions in April 2010, Staff Sergeant Krebs confirmed that none of the members of the MCMT had any substantive connections to the officers involved, but that Corporal Chauhan, who had previously worked in the Prince George Serious Crime Unit, may have had some previous professional dealings with Clay Willey. I am satisfied from the record that none of the investigative team had any substantial connection to any of the members involved in this incident.

FINDING: None of the members of the investigative team had a substantial connection to the members involved in this incident.

The investigation into Mr. Willey's death was considered to be a "small scaled investigation." When asked by the Commission whether the MCM model worked well in this case, Staff Sergeant Krebs replied: "No, it was under resourced. Changes implemented since this investigation and over the past six+ years are more efficient, comprehensive and impartial." This may account for some of the critical errors made during the investigation, as discussed below.

Scene Security

As in any major criminal investigation, securing the scene to ensure the preservation of physical evidence is a critical task. While the scene was not immediately secured following the arrest, it was reasonable not to do so until it became evident that Mr. Willey had suffered a major injury or was at risk of death. Constable Vince Foy was assigned to secure the scene at 6:40 p.m. and attended with Constable Graham, who showed him where the incident took place. However, Constable Foy's notes indicate that he took Constable Graham back to the detachment before returning to set up the perimeter and maintain security. There

is no indic ation that any other member was present at the scene to ensure its preservation. Leaving the scene unattended, even for a brief period of time, can result in the loss or destruction of physica l evidence and affects the integrity of the investigation. In my v iew, the Prince George RCMP Detachment failed to ensure that the scene was properly secured.

FINDING: The scene of Mr. Willey's arrest was not properly secured prior to the arrival of the North District MCU investigation team.

Collection of Physical Evidence

Corporal Glen Doll, with t he Prince George Forensic I dentification Section (FIS), was called at approximately 6:45 p.m. and arrived at the sc ene of the arrest shortly thereafter. The FIS is responsible for pr oviding inve stigative support services for front line polic ing. They attend crime scenes, photograph any evidence found and do forensic examinations wit h the hopes of locating fingerprints or other physical evidence.

Corporal Doll and his team marked, measured, and photographed the area, and swabbed t he areas of bloo d letting on the pav ement. In the days following Mr. Willey's arrest and subseque nt death, members of the FIS also obtain ed and processed the video evidence that was seized from the detachment.

FINDING: Members of the Forensic Identification Section attended and processed the scene of the arrest in a timely manner.

A number of articles were collected and processed as exhibits, including the CEWs used by the members, the ce ll block videotapes (addr essed later in this report), a boot and pants belonging to Co nstable Graham (which c ontained blood smears), blood s wabs collected by the FIS mem bers, a running shoe left behind by Mr. Willey, and a ce llular pho ne that was apparently dropped b y Mr. Willey an d which had been believed by Mr. Fawcett to be a knife.

As noted above, members of the FIS processed the scene of the arrest (the parkade at Parkwood Mall). Swabs we re collected; measurements and photographs were taken. Blood spatter was also found on the ri ght front corner of Constable Graham's vehicle, Unit 13B1. Photographs and swabs were collected from the vehicle. Although Staf f Sergeant Krebs re calls that the police v ehicle parked at the parkade by C onstable Fowler, Unit 13B16, was examined, there are no notations or photographs in the file to support that.

As a member of the investigative team, Constable Parmar was designated to make notes at the scene. According to his notes, he examined Unit 13A1 (the Suburban) at 7:31 p.m. and observed blood stains. However, it appears arrangements were not made with the FIS to ta ke photographs or samples from the Suburban at that time. Unfortunately, that vehic le, alt hough it was situated at the scene, was no t

preserved for expert examination and was subsequently cleaned. It was not photographed until after it had been cleaned.

Immediately following the incident, Staff Sergeant Scott examined the boots and pants of Constable Rutten. Perhaps relying on his experience as a member of the Forensic Identification Section, he determined that there was no evidence to be gleaned from further examination of those items. (Staff Sergeant Scott did collect Constable Graham's pants and boots, which contained some blood splatter.) Use of force was a key issue in this investigation. As it turned out, Constable Rutten reported that he had kicked Mr. Willey twice. At the coroner's inquest, counsel for the family asked witnesses about marks on the body that could be related to those kicks. Investigators should have collected the footwear worn by Constable Rutten to photograph the tread pattern for potential comparison against the body and Mr. Willey's clothing.

Mr. Willey was initially suspected of having a knife, which was later determined to be a cell phone. The cell phone was collected at the scene by Constable Lisa MacKenzie, who turned it over to Corporal Bob Pilot. It appears that the phone was inadvertently dropped by Corporal Pilot in the parking lot of the hospital and picked up by someone associated with the Willey family. Corporal Chauhan was the exhibit custodian and collected exhibits from Corporal Pilot; however, the cell phone was not amongst them and it was never identified as missing. Moreover, the cell phone was not retrieved by the RCMP from the family's lawyer until recently, many years after the incident occurred. The fact that the cell phone was collected and turned over to Corporal Pilot was clearly documented in the report submitted by Constable MacKenzie. It should have been apparent to investigators that the cell phone (a potentially important piece of evidence) was missing, but that was never determined.

While none of these procedural errors/oversights would necessarily be determinative or change the ultimate conclusions of the investigation, they affect the overall integrity of the investigation.

FINDING: The MCU investigative team erred in not having the police vehicle used to transport Mr. Willey examined prior to being cleaned.

FINDING: The MCU investigative team should have collected Constable Rutten's footwear as potential evidence.

FINDING: The MCU investigative team failed to recognize that a piece of evidence (Mr. Willey's cell phone) had been lost.

Witnesses

As the events leading up to the arrest of Mr. Willey and the arrest itself occurred in public places, there were a number of civilian witnesses to these events. In cases like this, the police sometimes have to rely on members of the public coming

forward to identify themselves as witnesses. Statements were taken from the civilian witnesses immediately following the incident or otherwise upon being identified.

I note that counsel for the family identified several additional witnesses and provided the RCMP with statements from those witnesses. Three of the persons identified did not witness any portion of the event; two persons witnessed a portion of the arrest and provided statements that were generally consistent with that of the majority of other witnesses; one witness provided an account that was substantially different from the majority of other independent witnesses and so was reasonably determined not to be credible.

In my view, there is no evidence that the investigators failed to locate or interview any relevant witnesses in a timely manner.

FINDING: All of the relevant witnesses were located and interviewed in a timely manner.

Duty to Account and Member Statements

As part of their duties, police officers are required to document their involvement in events which occur as a result of their employment and to provide that documentation to their employer. Such documentation must also be disclosed by operation of law to defence counsel or as directed by the courts with respect to judicial processes.

As a general rule, persons in Canada are under no legal obligation to provide a statement to the police. The police may request that a person provide a statement to them during an investigation but, absent some statutory or common law duty to comply, they have no means to enforce the request. However, RCMP members are required to provide an "account" of their activities when directed to do so. The authority to compel RCMP members to provide an accounting is derived from the fact that RCMP members are required to obey a lawful order from another RCMP member who is superior in rank or who has authority over the member. There is no similar requirement for ordinary citizens in the normal course of police investigations.

At the time of Mr. Willey's arrest and subsequent death, the RCMP did not have a clear policy explaining to members their obligations in providing an account of events when they are involved with or witness to a serious incident. In the Commission's report on the in-custody death of Ian Bush [32] (issued in November 2007), it was recommended that the RCMP develop a policy that dictates the requirement, timeliness and use of the duty to account that members are obliged to provide. Only recently has the RCMP finalized such a policy. [33] It provides (amongst other things) that:

[32] Commission file no. PC-2006-1532, November 27, 2007.
[33] RCMP *Operational Manual*, chap. 54.3 – Responsibility to Report, sections 2 and 5.2.

- A member has a legal, moral and professional obligation to provide a prompt report describing a police incident, what actions they took, their rationale and any observations made during the incident.
- All members (whether or not they were directly or indirectly involved in actions that may have contributed to a death or serious injury) may be required to provide a preliminary report (containing basic information about the incident) to investigators either immediately or soon after a serious incident and may be required to do so before consulting with anyone (including legal counsel).
- Witness members who were not involved directly or indirectly in the serious incident are required to provide a detailed report before going off duty (unless there are exceptional circumstances).
- Witness members who were involved directly or indirectly in the serious incident are required to provide a detailed report within a reasonable time, not to exceed 10 working days.

It may be that the lack of such a policy at the time of the incident resulted in the members' failure to provide timely accounts of the event and the failure of investigators to request more timely accounts. Staff Sergeant Scott had sent the members of his watch (the primary members involved in the incident) home prior to the arrival of the MCMT investigators. He instructed them not to discuss the matter between themselves. Some members suggested that they stay around to make statements. Staff Sergeant Scott did not feel that was appropriate and thought that it could be done the following day. The members returned the next evening to meet with counsel and prepare their occurrence reports. In his notes confirming knowledge of this meeting, Constable Lynch stated: "It is hoped that interviews can be conducted once this group meeting has been held." It was not until the morning following this meeting—more than 36 hours after the incident—that counsel provided the members' written reports to Staff Sergeant Krebs.

There are obvious concerns raised with the failure to obtain timely accounts from the involved members in addition to their meeting as a group, whether it be with legal counsel or otherwise. To paraphrase an old maxim, an impartial investigation must not only be done, it must be seen to be done. This is particularly true when the police are investigating the police. Investigative basics are that witnesses should be separated immediately to remove the potential opportunity for them to tailor their evidence or to concoct a version of events. Time and opportunity to discuss the events together or with a shared legal counsel at best creates the appearance of potential interference and at worst can result in actual interference with an ongoing investigation.

In my view, the investigator is at liberty to obtain at least a basic account from an involved member without anyone potentially having first discussed the facts of the situation with the member. That did not occur in this case. Current policy reflects and clarifies that requirement. As such, while I find that the investigators failed to

request at least preliminary accounts from the involved members in a timelier manner, I make no recommendations, as current RCMP policy has been implemented to help address that issue.

FINDING: The investigators failed to obtain at least preliminary accounts from the involved members in a timely manner.

The investigative team did conduct oral interviews with a number of members after their written reports were received. I note that those members were not compelled to participate in such interviews but did so voluntarily. However, interviews with the two primary members who dealt with Mr. Willey at the detachment fell well below the standard expected in an investigation of such a serious incident.

The interview of Constable Caston took place over six minutes. The interview of Constable O'Donnell took place over five minutes. The majority of that time was spent asking and answering such questions as "What items do you carry on your duty belt?", "Were you carrying a CEW?", "Were you trained to use the CEW? If so, when?", and "Describe how Mr. Willey was hog-tied." These questions are more of a "housekeeping" nature, and did not address any of the "whys" of the members' conduct. Since members must clearly articulate their reasons to justify any use of force, the "whys" were key to the investigation.

With respect to the manner in which Mr. Willey was transported from the police vehicle and through the hallway to the elevator, it was clear from the detachment video that Mr. Willey was dragged by his feet, face down. However, the reports of several of the members paint a different picture. Constables O'Donnell and Edinger make no specific mention of how Mr. Willey was carried, and no clarification was sought from them by investigators. However, in their written reports Constable Scott describes how Mr. Willey was picked up by the shoulders and Constable Caston stated: "With members holding his upper torso off of the ground by his upper arms." Yet investigators never questioned the members on the clear discrepancy between their statements and the video. (The members were also never asked to explain why they "carried" Mr. Willey in the manner that they did.)

If for no other reason than to be fair to the responding members and give them an opportunity to address the significant and readily apparent discrepancies between their version of how Mr. Willey was transported and the video, it would have been appropriate to provide the responding members with an opportunity to view the detachment video. Investigators should have then given the members an opportunity to explain the discrepancy between their statements and the video. Failure to do so led the members to give the same evidence at the coroner's inquest, only to be clarified by the Willey family's counsel upon cross-examination of these members.

The improper use of force always has the potential to lead to criminal charges or a Code of Conduct proceeding. Whether or not the use of force is related to the cause of death, investigators have an obligation to conduct a criminal investigation into all aspects of an incident. As will be discussed below, there was some concern expressed by Crown counsel and others with respect to the transport of Mr. Willey; however, this issue was clearly not adequately probed by investigators.[34]

I note that the RCMP recently implemented policy that would see the investigations of serious incidents handled by external law enforcement agencies. The intent of the policy is "to ensure fair, effective, thorough and impartial investigations of RCMP employees through a combination of independent external investigation, observation and review."[35] The Commission commends the RCMP for implementing such a policy and is hopeful that investigation by an independent police agency will help to ensure that all aspects of an incident are adequately canvassed by investigators.

FINDING: The MCU investigators failed to adequately question the members involved in this incident with respect to their use of force.

Use of Force Expert Report

Where there are concerns about the force that was used by police, particularly where a person is seriously injured or dies, it is generally appropriate to obtain an opinion from a use of force expert. According to the notes of Constable Parmar, the first contact was made with use of force experts within the RCMP regarding CEW use on the day following Mr. Willey's arrest. However, the final investigation report that was sent to Crown counsel, dated September 16, 2003, did not include a use of force report.

Corporal Gregg Gillis was eventually retained to provide an opinion and testify at the coroner's inquest in October 2004. He was provided with disclosure materials (the same as was provided to Crown counsel) on November 4, 2003. In my view, the MCU should have obtained a use of force report prior to completing its investigation report and prior to submitting it to Crown counsel. Such reports should be required in any situation where force is used and the subject suffers a serious injury or dies to ensure that the members' conduct is adequately assessed by a subject-matter expert.

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[34] I note that during the course of the Commission's public interest investigation, the Commission sought to clarify the intentions and actions of the members. All members were contacted and given the opportunity to participate in an interview or answer questions in writing regarding their involvement in the Willey matter. It has been more than six and one-half years since the incident. Most of the involved members have been promoted and moved on to other duties. Many decided to exercise their legal right not to provide an interview or statement, including constables Caston and O'Donnell.

[35] RCMP *Operational Manual*, chap. 54.1 – RCMP External Investigation or Review, section 2.1.

FINDING: An expert on use of force should have been identified earlier on during the investigation and a report prepared, the opinion considered by investigators and then forwarded to Crown counsel.

RECOMMENDATION: Where the RCMP investigates itself in situations where force is used and the subject suffers a serious injury or dies, a use of force report should be required prior to review by Crown counsel.

Independent Officer Review

The circumstances related to the death of Mr. Willey were also reviewed as part of an Independent Officer Review (IOR). An IOR is an internal administrative review. In the Commission's report *Police Investigating Police – Final Public Report*,[36] it recommended that administrative reviews be undertaken in all cases of serious injury, sexual assault, or death. The mandate of the reviewer is to conduct a fact-finding inquiry to ensure that:

- a thorough, professional and unbiased investigation is conducted;
- training, officer safety skills, approved procedures and tactics and policy are appropriate and were followed;
- appropriate information has been provided to agencies such as Crown counsel and/or the Coroner's Service; and
- the member(s) conduct is in accordance with the RCMP Act *and Regulations*.

Inspector Tom Gray was assigned to conduct an IOR in the Willey matter. He advised the Commission's investigator that it was his first such review. Although, by virtue of his experience, he was well qualified for this task, he was left to his own devices; there was no policy document to guide him.

Inspector Gray acknowledged that he was looking at Code of Conduct concerns. But under the RCMP Act, the Commander is responsible for initiating a Code of Conduct complaint. He spoke on the telephone with the investigators in the early days of the investigation and travelled to Prince George and met with the Team Leader, Staff Sergeant Krebs, and the Primary Investigator, Constable Lynch. He indicated that he had confidence in the investigation and believed that investigators had an obligation to bring any conduct issues to his attention.

Inspector Gray also received a copy of the final investigative report and used that as the basis for his preliminary report, which he wrote shortly after his visit to Prince George. He attended the coroner's inquest as an observer. At the inquest, he felt the members gave evidence in a straightforward manner. He saw the video at the inquest, but from a distance and it was difficult to follow.

[36] See the Commission's report, released on August 11, 2009, at www.cpc-cpp.gc.ca/nrm/nr/2009/20090811-eng.aspx.

In his report, Inspector Gray noted that th e use of the CEW in t he ce llblock was "ill-advised," but he was satisfied that t here was no intention to cause Mr. Willey harm. In his view, the wrong decision was made in bringing Mr. Willey to the cells rather than to the hos pital. He acknowledged that th e members did some things wrong, but they did not know any better; the RCMP has l earned from that situation and others.

In his interview with the Commis sion, Inspector Gray acknowledged that there was an obvious concern in the manner in which members removed Mr. Willey fro m the vehicle and took him to the cells. He advised that he thought about the situation and conc luded that the members did not int end to hurt Mr. Willey. He fe lt the members explained t hemselves at the inq uest. Inspector Gray indic ated that he raised his concerns with Divisional Commander Dahl Chambers after the coroner's inquest, but he told him that he was no t leaning t owards a Code of Conduct recommendation in the IOR. However, he acknowledged to the Commission that the members did not think it through and did not respect Mr. Willey's dignity.

Several iss ues arise with respect to the IOR process itself and the relationship between the IOR and the MCU in vestigation. While Inspector Gray acknowledged that he had concerns, these concerns were not all addressed in his report. He was not aware of who read his report and he did not have any discussions with anyone about it after it was s ubmitted. He in dicated to the Commission that he has never received feedback on his IOR reports, which he views as problematic.

Inspector Gray's role was to conduct an ad ministrative review. He was not to be an investigator. He was to rely on the wo rk of the MCU inv estigative team. In my view, this process was flawed. From t he investigation docum ents and interviews conducted by the Commission, it seems that there was a gap between what the MCU saw as its role—to investigate cr iminal conduct only—and the role of Inspector Gray in completing the IOR and to measure the conduct of the members against policy and training. However, the investigation itself was not concerned with conduct issues.

According to Staff Sergeant Kr ebs, the M CU inv estigation was directed at the cause of death and was char ged with the responsibilit y of determining whether there was criminal lia bility on the part of any member of the RCMP. Once the pathologist confirmed that the death was attributable to a cocaine overdos e, the investigation effectively ended. When asked by the Commission why, for example, there was no interview done with Const able Jan a Scott to clarify how she described the transport of Mr. Willey against what wa s seen on the vid eo, h e responded:

> I can only comment that this wa s not a critical point of our investigation as the manner in which Clay WI LLEY was transported did not constitute a criminal act or responsible for his death.

However, at points during the investigation, Staff Sergeant Krebs describes it as a coroner's case rather than a criminal investigation, which indicates some confusion over mandate. The following wording was approved for a press release:

> There is no criminal investigation underway, however, an independent internal RCMP review continues as part of RCMP's Policy on in custody deaths. North District Major Crime Unit continues to investigate as an assistance to the Coroner's Office.

As noted earlier in this report, the MCU investigation did not adequately address issues around the force that was used. This becomes problematic for the IOR process, which relied too heavily perhaps on the MCU investigation given its different mandate. For example, Inspector Gray was left to assume the intent of the members with respect to their use of force, as it was not adequately addressed in the members' reports and the members were not questioned about these aspects of the incident.

Regrettably, conduct issues and breaches of policy went unidentified. It is of note that the RCMP recently implemented an external investigations policy that would see investigations such as the one into the in-custody death of Mr. Willey delegated to an external investigative body. Whether an investigation is conducted by the RCMP or an outside police agency in accordance with its external investigations policy, I recommend that the RCMP clarify the roles of each investigative/reviewing party to ensure that both the criminal and conduct aspects of an investigation are adequately addressed. This way, critical opportunities to address shortcomings in behaviour or policy and training will not be missed.

FINDING: Neither the criminal nor conduct aspects of the police involvement in Mr. Willey's death were adequately investigated or addressed.

RECOMMENDATION: The RCMP should clarify the roles of the investigative and reviewing parties to ensure that both the criminal and conduct aspects of an investigation are adequately addressed

Review by Crown Counsel

In British Columbia, the police require the approval of Crown counsel before laying charges. One of the roles of Crown counsel is to *approve* and conduct, on behalf of the Crown, all prosecutions of offences in the Province. [37] In determining whether a charge is to be approved for prosecution, the substantial likelihood of conviction standard is used. A substantial likelihood of conviction exists where the

[37] See section 4 of the *Crown Counsel Act* of British Columbia.

prosecutor is satisfied that "there is a strong, solid case of substance to present to the court."[38]

RCMP investigation guidelines provide that "[i]f there is evidence to support a prosecution, consult Crown counsel."[39] Inspector Gray told the Commission that he recommended that the investigative team submit a report to Crown counsel whether or not they were recommending charges in the interest of transparency. The RCMP submitted its investigation report to Crown counsel, including the relevant documentation and statements. On January 14, 2004, Crown counsel wrote to the RCMP to confirm that it had determined, in relation to the force used against Mr. Willey, that there was no substantial likelihood of conviction and that no charges would be approved. I do note that Crown counsel indicated that there were "some problematic aspects of police conduct in this case," including the use of the CEW.

Other Review Processes

a) Public complaint

In January 2004, a complaint was filed with the Commission by a member of the public with respect to the circumstances surrounding the RCMP's involvement in Mr. Willey's death. As per the provisions of the RCMP Act, the complaint was sent to the RCMP for investigation, and a Final Report was sent to the complainant by the RCMP in November 2006. The RCMP relied on the results of the coroner's inquest, the MCU investigation, and the review by Crown counsel to conclude that no abuses or misconduct by the police officers involved had been identified. The complainant did not file a request for review of that decision with the Commission.

b) Directed review (review by outside/independent agency)

As noted above, the issue with respect to the integrity of the video evidence and the treatment of Mr. Willey while in custody arose again in late 2009. At that time, the RCMP enlisted the assistance of the Edmonton Police Service to conduct a review of its investigation.

With respect to the conduct of the members, the reviewing officer from the Edmonton Police Service identified the following issues: 1) use of the hog-tie restraint as it was outside of policy at the time of the occurrence; however, he accepted the explanation provided by the member; 2) use of the CEW in the cell area; he found that it was unnecessary but not outside of their training and policy as it existed at the time of the incident; and 3) the decision not to transport Mr. Willey directly to the hospital; however, current policy now reflects the need to have medical assistance attend any scene involving anyone who may be exhibiting symptoms of "agitated delirium."

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[38] See www.ag.gov.bc.ca/prosecution-service/crim-court-proc/adult.htm.
[39] RCMP *Operational Manual*, chap. II.1 – Investigation Guidelines, section F.2.

With respect to the investigation and IOR, the reviewing officer did not identify "any significant concerns with the thoroughness, professionalism and impartiality of the investigation conducted by North District Major Crimes Unit investigators that would be counter to any of Inspector Gray's findings."

In conclusion, the reviewing officer stated: "I have conducted a complete review of all the material and I cannot make any new recommendations or come too [*sic*] any different conclusions than those in previous reviews."

c) Code of Conduct

In late 2009, the RCMP also instituted Code of Conduct investigations with respect to the involvement of constables Caston and O'Donnell in this incident. At the time of writing this report, final decisions have not yet been made in those investigations. However, the Commission understands that the members' line officers have recommended that no disciplinary action be taken.

It was open to the RCMP to launch such investigations immediately following the incident in 2003. The authority to initiate such an investigation is pursuant to section 40, found in Part IV of the RCMP Act. It reads as follows:

> 40. (1) Where it appears to an officer or to a member in command of a detachment that a member under the command of the officer or member has contravened the Code of Conduct, the officer or member shall make or cause to be made such investigation as the officer or member considers necessary to enable the officer or member to determine whether that member has contravened or is contravening the Code of Conduct.

However, as noted earlier in this report, the IOR did not recommend any Code of Conduct investigations and, to my knowledge, no new information has come to the RCMP's attention. Section 43(8) of the RCMP Act stipulates that no formal disciplinary hearing into an allegation that a member has contravened the Code of Conduct may be initiated more than one year from the time the contravention and the identity of that member become known to the Commanding Officer of the region in which the impugned member is serving. As such, it appears that any misconduct that is identified in this report cannot be the subject of a formal disciplinary hearing.

Timeliness of Investigation

An area of concern regarding investigations generally is the amount of time it takes to complete the investigation. In its Police Investigating Police report, the Commission has set out a baseline definition of what constitutes a "timely" response by the investigative team. The key features of appropriate timeliness of member investigations include the following:

1. Member investigation undertaken and completed in six months (or less).
2. Investigations, if possible, should not exceed one year.[40]
3. Immediate dispatch of necessary personnel where timely response required.

As noted above, I found that the appropriate investigative personnel were contacted and dispatched to the scene in a timely manner. A diagram setting out the timeline of the investigation can be found at **Appendix G.** A review of the investigative file reveals that most of the investigation was completed within a 72-hour period. During the first 72 hours, the FIS gathered forensic evidence, witnesses were identified and interviewed, and RCMP members provided the required reports. Interviews that were not completed within the first 72 hours were concluded by Corporal Chauhan on July 28th.

The key aspects of the investigation were completed and expert reports obtained well within six months of the incident. While there were some deficiencies in the investigation itself, as noted earlier in this report, it was conducted in a timely manner.

FINDING: There was no unreasonable delay in the RCMP's investigation of Mr. Willey's death and it was completed in a timely manner.

[40] This is particularly important given that when an investigation of a member takes more than one year to complete (regardless if a criminal charge is ultimately laid), section 43(8) of the RCMP Act then prohibits any Code of Conduct action against the offending member.

THIRD ISSUE: THE VIDEO EVIDENCE – Whether any other video evidence (other than the compilation video shown at the coroner's inquest) exists and whether any RCMP member concealed, tampered with or otherwise inappropriately modified in any way, any evidence, in particular any video evidence, relating to the arrest of Mr. Willey.

ANALYSIS – INTEGRITY OF THE VIDEO EVIDENCE

As part of the public interest investigation into this matter, the Commission's investigator met with members of the Willey family to discuss allegations that the Prince George Detachment videotapes had been tampered with. The Willey family has told the Commission that it believes that, as part of an alleged cover-up, critical information showing how Clay Willey was treated while in police custody has been edited out of the RCMP videotapes.

To provide some background, a few weeks before the coroner's inquest began in October 2004, counsel for the family was given a copy of the video to help prepare them to receive the evidence that would be called during the inquest. The family's lawyer was not permitted to keep a copy of the video, but only to review it with the family and return it, which he did. Various members of Mr. Willey's family insist they saw video footage of Mr. Willey being removed from the police vehicle. They claim to have watched that portion several times and saw Mr. Willey's head bounce off the floorboard of the police vehicle and land on the cement floor. During the inquest, a video was shown which did not include the segment where Mr. Willey was removed from the police vehicle.

As part of the RCMP's investigation into these allegations in November 2009, the RCMP requested that Martin Schouten, a Forensic Video Analyst, perform a number of examinations on the videotapes. Mr. Schouten completed that work and submitted his report on December 7, 2009. Mr. Schouten commented on the frozen video footage that would have otherwise shown Mr. Willey being removed from the police vehicle but instead shows a frozen image. He indicated that it is "highly unlikely' that the frozen image was the result of human intervention; but given the limited information on the closed- circuit television system as it existed in 2003, Mr. Schouten could not determine the exact cause of the missing video.

Under the circumstances, in order to preserve the integrity of the Commission's investigation, the Commission retained the services of an independent certified forensic video analyst (a civilian employed by the Forensic Identification Support Services branch of the Ontario Provincial Police) to verify the integrity of the video evidence in this matter. The main objectives of the analysis were to determine whether or not the videotapes provided by the RCMP were the original video recordings from the incident and whether or not the portion of the videotape where Mr. Willey is being removed from the vehicle had been tampered with—i.e. whether any portion had been removed or added, or otherwise altered in any way.

The video expert determined, using various scientific methods, that the videotapes provided to the Commission were, in fact, the original videotapes and had not been altered in any way. From those videotapes, he was able to create for the Commission a viewable video presentation of the time Mr. Willey spent in RCMP custody at the Prince George Detachment, which has been referenced throughout this report. The camera angle that should have shown Mr. Willey's removal from the police vehicle displayed a frozen image. The video expert determined that this was a function of the video recording system and was not the result of human intervention.

The video expert did, however, note some discrepancies between the copy created by the RCMP and shown at the coroner's inquest and the original videotape, as well as an initial copy that had been provided to the coroner's office. The discrepancies were in the form of missing frames [41] that were otherwise captured on the original videotapes. The video expert could not determine why frames were missing from the copies—i.e. whether it was the result of user error in the processing of the video, the fault of the equipment used in doing so, or whether the person processing the video chose to exclude certain portions of video. However, the Commission has reviewed all of the video footage in detail and has determined that the additional frames did not materially add to the general presentation of the video record of what happened to Mr. Willey.

The Commission's expert explained his findings to the Willey family in person prior to the writing of this report. I understand that despite his conclusions, in which the Commission has full confidence, the family is convinced that they saw what would have otherwise been in the place of the frozen image. According to a member of Mr. Willey's family, their counsel raised the matter at the inquest and there were discussions about the missing segment. The Commission sought clarification from that counsel, who confirmed that he believed that would be evident in the transcripts of the inquest.

The Commission has reviewed the transcripts from the coroner's inquest in detail. No issue was raised with respect to any missing footage. However, there was an issue raised with respect to Mr. Willey's transport. As noted above, the members reported carrying Mr. Willey by the arms (i.e. lifting his torso off of the ground), whereas the video footage showed that he was dragged by the feet with his face on the floor. Counsel for the family cross-examined the members to clarify what was shown on the video. Otherwise, no issues arose from the video at the inquest.

FINDING: The videotapes provided by the RCMP to the Commission were the original videotapes depicting Mr. Willey's detention at the detachment.

[41] At the time, the Prince George RCMP Detachment's video recording system consisted of an analog closed-circuit television (CCTV) system. The individual camera views throughout the detachment were recorded in a multiplexed format, which were required to be de-multiplexed for normal viewing. A video frame consists of a picture in time as recorded by the analog system.

FINDING: The frozen video image which would have otherwise shown Mr. Willey's removal from the police vehicle was a result of the video recording system, and not the result of human interference.

As noted above, the expert retained by the Commission determined that the frozen video footage was a result of the functionality of the analog recording system. I note that the Prince George RCMP Detachment has since moved to a digital video recording system (a recommendation from the Independent Officer Review that was implemented), which should eliminate such issues in the future.

I also note that there was an issue with the quality of the video recording that was shown at the coroner's inquest. By all accounts, it was difficult to view. The Commission was provided with that video. Two issues arise from it: With respect to the quality of viewing, the video analyst retained by the Commission was able to assemble a much clearer version using software and technology that was available at the time the incident occurred. In cases as serious and important as an in-custody death, the RCMP should ensure that all video evidence is processed by a person with the requisite training and experience, and with adequate resources to do so.

As noted above, there were also portions of footage which were not included in the copy to the coroner. While they did not materially affect the overall picture of what happened while Mr. Willey was at the detachment, the RCMP should make efforts, in the interest of full disclosure, to ensure that all footage is disclosed. It is unknown whether the missing frames were the result of a member's decision not to include particular frames (potentially because they were deemed not to be relevant), whether it was a lack of training or experience with the equipment or software, or otherwise. It is important to avoid any situation where the same actions could result in missing footage that is entirely material to the investigation and determinations to be made. The preservation of video evidence is extremely important, as it is often the only objective accounting of what transpired.

RECOMMENDATION: The RCMP should take steps to ensure that any video footage is made available in its entirety and in a viewable format to the coroner's office in the case of an in-custody death and is retained as part of the investigation record.

CONCLUSION

It is difficult for both the police and the public to critically examine violent encounters between the police and a member of the public. In this case, what had begun as a public disturbance requiring police involvement turned into what was later determined to be a medical emergency. Since this incident and others similar to it, much has been done by the RCMP to train members to recognize and deal with such difficult situations. However, while it is clear from the medical evidence and the findings of the BC Coroner that the force used by the members did not cause the death of Clayton Willey, the RCMP must nonetheless take responsibility for the mistreatment of Mr. Willey while he was in its custody.

It is important to note that this incident and the subsequent investigation took place in 2003. The Major Case Management model was quite new in 2003 and the divisional infrastructure was not sufficiently advanced to support its use. Many improvements have been made to the RCMP's procedures and policies governing investigations of in-custody deaths. The Commission is encouraged by the RCMP's steps to ensure that future major incidents are investigated by independent police agencies.

Pursuant to subsection 45.43(3) of the RCMP Act, I respectfully submit my Public Interest Investigation Report.

Ian McPhail, Q.C.
Interim Chair

APPENDIX A

Summary of Findings and Recommendations

FINDING: The members entered into their interactions with Mr. Willey lawfully and were duty-bound to do so.

FINDING: The force used by constables Graham and Rutten to arrest and apply handcuffs to Mr. Willey was reasonable in the circumstances.

FINDING: Constable Rutten's use of OC spray during the struggle with Mr. Willey at the parkade was ill-advised, but not unreasonable in the circumstances.

FINDINGS

- **It was reasonable for Constable Graham to apply the hog-tie in the circumstances despite its use having been discontinued by the RCMP.**
- **The RCMP failed to implement its change in policy with respect to the discontinued use of the hog-tie and approved use of the RIPP Hobble in a timely manner.**

RECOMMENDATION: The Commission reiterates its recommendation in its report respecting deaths in RCMP custody proximal to the use of the CEW (July 2010) that "the RCMP develop and communicate to members clear protocols on the use of restraints and the prohibition of the hog-tie, modified hog-tie and choke-holds."

FINDING: Constables Graham, Fowler and Rutten utilized an appropriate level of force when effecting the arrest of Clay Willey on July 21, 2003.

FINDING: Constables Scott and Edinger failed to secure their firearms upon arrival at the detachment as required by RCMP policy and were not justified in deviating from that policy.

FINDING: It was not an appropriate use of force for Constable Scott to have her firearm drawn at the time of Mr. Willey's removal from the police vehicle.

FINDING: Constables Caston and O'Donnell failed to treat Mr. Willey with the level of decency to be expected from police officers when they removed him from the police vehicle and transported him to the elevator.

FINDING: The simultaneous use of the CEW by constables Caston and O'Donnell was unreasonable, unnecessary and excessive in the circumstances.

FINDING: Constables Caston and O'Donnell failed to adequately document their use of the CEW and in a timely manner.

FINDING: Constable Graham failed to obtain medical assistance for Mr. Willey in a timely manner. Having reasonably concluded that it was a safety issue to bring Mr. Willey to the hospital, it would have been more appropriate for Constable Graham to have arranged for an ambulance to meet the members and Mr. Willey at the Prince George RCMP Detachment.

FINDING: The RCMP failed to communicate all relevant information about Mr. Willey and his arrest to the ambulance attendants.

RECOMMENDATION: The Officer in Charge of the Prince George RCMP Detachment should take steps to ensure that all members are cognizant of the need to provide all relevant information to medical personnel.

FINDING: The Major Crime Unit was deployed to investigate Mr. Willey's arrest and subsequent death in a timely manner and in accordance with RCMP policy.

FINDING: None of the members of the investigative team had a substantial connection to the members involved in this incident.

FINDING: The scene of Mr. Willey's arrest was not properly secured prior to the arrival of the North District MCU investigation team.

FINDING: Members of the Forensic Identification Section attended and processed the scene of the arrest in a timely manner.

FINDING: The MCU investigative team erred in not having the police vehicle used to transport Mr. Willey examined prior to being cleaned.

FINDING: The MCU investigative team should have collected Constable Rutten's footwear as potential evidence.

FINDING: The MCU investigative team failed to recognize that a piece of evidence (Mr. Willey's cell phone) had been lost.

FINDING: All of the relevant witnesses were located and interviewed in a timely manner.

FINDING: The investigators failed to obtain at least preliminary accounts from the involved members in a timely manner.

FINDING: The MCU investigators failed to adequately question the members involved in this incident with respect to their use of force.

FINDING: An expert on use of force should have been identified earlier on during the investigation and a report prepared, the opinion considered by investigators and then forwarded to Crown counsel.

RECOMMENDATION: Where the RCMP investigates itself in situations where force is used and the subject suffers a serious injury or dies, a use of force report should be required prior to review by Crown counsel.

FINDING: Neither the criminal nor conduct aspects of the police involvement in Mr. Willey's death were adequately investigated or addressed.

RECOMMENDATION: The RCMP should clarify the roles of the investigative and reviewing parties to ensure that both the criminal and conduct aspects of an investigation are adequately addressed.

FINDING: There was no unreasonable delay in the RCMP's investigation of Mr. Willey's death and it was completed in a timely manner.

FINDING: The videotapes provided by the RCMP to the Commission were the original videotapes depicting Mr. Willey's detention at the detachment.

FINDING: The frozen video image which would have otherwise shown Mr. Willey's removal from the police vehicle was a result of the video recording system, and not the result of human interference.

RECOMMENDATION: The RCMP should take steps to ensure that any video footage is made available in its entirety and in a viewable format to the coroner's office in the case of an in-custody death and is retained as part of the investigation record.

APPENDIX B

RCMP Members Involved in the In-Custody Death of Clay Willey and Subsequent Investigation[42]

RCMP Members Involved with the Arrest of Clay Willey on July 21, 2003

Person	Detachment	Role
Constable Holly Fowler	Prince George	First responder. First member to encounter Mr. Willey. Assisted constables Graham and Rutten in restraining Mr. Willey.
Constable John Graham	Prince George	First respon der. Arrested Mr. Willey and took him to the ground.
Constable Kevin Rutten	Prince George	First responder. Assisted constables Graham and Fowler in restraining Mr. Willey.
Constable Lisa MacKenzie	Prince George	First respo nder. Was not involved in physically restraining Mr. Willey.

RCMP Members Involved with the Transport and Detention of Clay Willey on July 21, 2003

Person	Detachment	Role
Constable Glenn Caston	Prince George	Transported Mr. Willey from scene of the arrest to the Prin ce George RCMP Detachment. With the assist ance of Constable O'Donnell, removed Mr. Willey from the police vehicle and transported him to the cell block area. Physically restrained Mr. Willey until the ambulance arrived. Used his CEW against Mr. Willey. Accompanied Mr. Willey in the ambulance.
Constable Kevin O'Donnell	Prince George	With the assistance of Constable Caston, removed Mr. Willey from the police vehicle and transported him to the cell block area. Physically restrained Mr. Willey until the ambulance arrived. Used his CEW against Mr. Willey. Accompanied Mr. Willey in the ambulance.

[42] Positions and ranks noted as at the time of the events.

Constable Jana Scott	Prince George	Provided “lethal force over watch” during the removal of Mr. Willey. Was present in the cell block area durin g much of t he time that Mr. Willey was there.
Constable John Edinger	Prince George	Assisted co nstables Ca ston and O’Donnell with transporting Mr. Willey from the security bay area to the elevator.

RCMP Members from the Investigation Team

Person	Detachment	Position	Role
Sergeant Glenn Krebs	Prince George	North District Major Crime Unit	Team Leader/Commander
Constable Alex Lynch	Prince George	North District Major Crime Unit	Primary Investigator and File Coordinator
Corporal Dave Chauhan	Prince George	North District Major Crime Unit	Exhibits Coordinator
Constable Sukh Parmar	Prince George	North District Major Crime Unit	Investigator

APPENDIX C

Chair-Initiated Complaint & Public Interest Investigation – In-Custody Deaths Proximal to CEW Use

As Chair of the Commission for Public Complaints Against the RCMP (Commission), I am initiating a complaint into the conduct of those unidentified RCMP members present at, or engaged in, incidents where individuals in the custody of the RCMP died following the use of a conducted energy weapon (CEW), which incidents have taken place anywhere in Canada between January 1, 2001 and January 1, 2009.

The facts as are currently known indicate that since the commencement of the use of the CEW by the RCMP in 2001, a number of individuals have died while in the custody of the RCMP following utilization of a CEW.

Given the ongoing expressions of concern of the public and the Commission as they relate to deaths of individuals while in the custody of the RCMP as well as with respect to the degree and type of force required by police officers when effecting an arrest and, as in these cases, the specific concerns raised in respect of the use of a CEW, including related training, policy, procedures and guidelines for deployment thereof, I am satisfied that there are reasonable grounds to investigate the conduct of all RCMP members involved in these incidents.

Accordingly, pursuant to subsection 45.37(1) of the RCMP Act, I am today initiating a complaint into the conduct of all RCMP members involved in these incidents, specifically:

1. whether the RCMP officers involved in the aforementioned events, from the moment of initial contact with the individual until the time of each individual's death, complied with all appropriate training, policies, procedures, guidelines and statutory requirements relating to the use of force; and
2. whether existing RCMP policies, procedures and guidelines applicable to such incidents are adequate.

Furthermore, I am instituting a public interest investigation into this complaint, pursuant to subsection 45.43(1) of the RCMP Act.

APPENDIX D

Correspondence from the BC Solicitor General

November 20, 2009

Mr. Paul E. Kennedy

Chair

Commission for Public Complaints
Against the RCMP

Bag Service 1722 Stn B

Ottawa ON K1P 0B3

Dear Mr. Kennedy:

I write further to our conversation of No vember 20, 2009 with respect to the death of Mr. Clayton Willey. As you are aware, his death was the subject of a coroner's inquest conducted by the British Columbia Coroner's Service in October, 2004. According to the verdict At Coron er's Inquest, Mr. Willey died in Prince George on July 22, 2003, approximately 16 hours after being apprehended by members of the Prince George RCMP Detachm ent following complaints of a public disturbance. One of the piec es of evidenc e consi dered at the coroner's inquest was a compilation of video footage from a number of security cameras located throughout the Prince George RCMP Detachment.

I first became aware of this issue following recent, widespread reports in the British Columbia media. Media have raised concerns with the in-custod y treatment of Mr. Willey and have e xpressed concern that the video in question has no t bee n released to the public. Allegations have al so been made in the media that further video evidence exists beyond that contained in the compilation video.

Following these media reports, I requested a briefing from my senior staff and the RCMP on this issue. On November 19, the RCMP provided my staff and me with a briefing on this matter, which included view ing of the compilation video. Followin g this meeting, and in light of growing pub lic co ncerns regarding this matter, I contacted you for the purpose of determini ng what further steps could be taken. I understand that your office is c urrently conducting a review of in-custody taser related deaths across the country and that t his incident forms part of your review. However, I understand the terms of referenc e of your current review are focussed on the involvement of tasers in these incidents.

My purpose in writing is to ensure that British Columbians have the benefit of a single, comprehensive and transparent accounting of the circumstances of Mr. Willey's death. It is my understanding that you have broad legislative powers to examine issues of this nature, including the ability to hold public hearings and hear testimony from witnesses.

At this time, I am requesting that you review the circumstances surrounding the death of Mr. Willey so that British Columbians can have continued confidence in the RCMP.

I appreciate your prompt attention to this matter.

Yours truly,

Kash Heed
Solicitor General

APPENDIX E

Amendment to Chair-Initiated Complaint & Public Interest Investigation – In-Custody Deaths Proximal to CEW Use

On January 15, 2009, I initiated a public complaint into the conduct of those unidentified RCMP members present at, or engaged in, incidents where individuals in the custody of the RCMP died following the use of a conducted energy weapon (CEW), which incidents have taken place anywhere in Canada between January 1, 2001 and January 1, 2009.

The arrest and subsequent death of Mr. Clayton Alvin Willey in Prince George, British Columbia on July 22, 2003 is one of the incidents referred to in the complaint. Mr. Willey's death was the subject of a coroner's inquest conducted by the British Columbia Coroner's Service in October 2004. One of the pieces of evidence considered at the Coroner's inquest was a compilation of video footage from a number of security cameras located throughout the Prince George RCMP Detachment.

The original complaint was initiated to examine:

1. whether the RCMP officers involved in the aforementioned events, from the moment of initial contact with the individual until the time of each individual's death, complied with all appropriate training, policies, procedures, guidelines and statutory requirements relating to the use of force; and
2. whether existing RCMP policies, procedures and guidelines applicable to such incidents are adequate.

I also commenced a public interest investigation into this complaint, pursuant to subsection 45.43(1) of the *Royal Canadian Mounted Police Act*.

Subsequent to the launch of my complaint and public interest investigation, the Solicitor General of British Columbia has on behalf of the residents of British Columbia, raised concerns directly with me regarding this incident and in particular with respect to the integrity of the video evidence relating to the arrest and detention of Mr. Willey. In correspondence to the CPC, the Solicitor General commented that members of the media have "raised concerns with the in-custody treatment of Mr. Willey and have expressed concern that the video in question has not been released to the public. Allegations have also been made in the media that further video evidence exists beyond that contained in the compilation video." Consequently, the Solicitor General requested that I "review the circumstances surrounding the death of Mr. Willey so that British Columbians can have continued confidence in the RCMP."

As such and without limiting the generality of the foregoing, I am expanding my public complaint and public interest investigation to examine:

3. whether the RCMP members involved in the investigation of Mr. Willey's arrest and subsequent death conducted an investigation that was adequate, and free of actual or perceived conflict of interest; and
4. whether any other video evidence (other than the compilation video referred to above) exists and whether any RCMP member concealed, tampered with or otherwise inappropriately modified in any way, any evidence, in particular any video evidence, relating to the arrest of Mr. Willey.

APPENDIX F

Canada *Criminal Code* Provisions

25. (1) Ev ery one who is requir ed or aut horized by law to do anything in the administration or enforcement of the law

(a) as a private person,
(b) as a peace officer or public officer,
(c) in aid of a peace officer or public officer, or
(d) by virtue of his office,

is, if he acts on reasonable gr ounds, justifi ed in doing what he is requir ed or authorized to do and in using as much force as is necessary for that purpose.

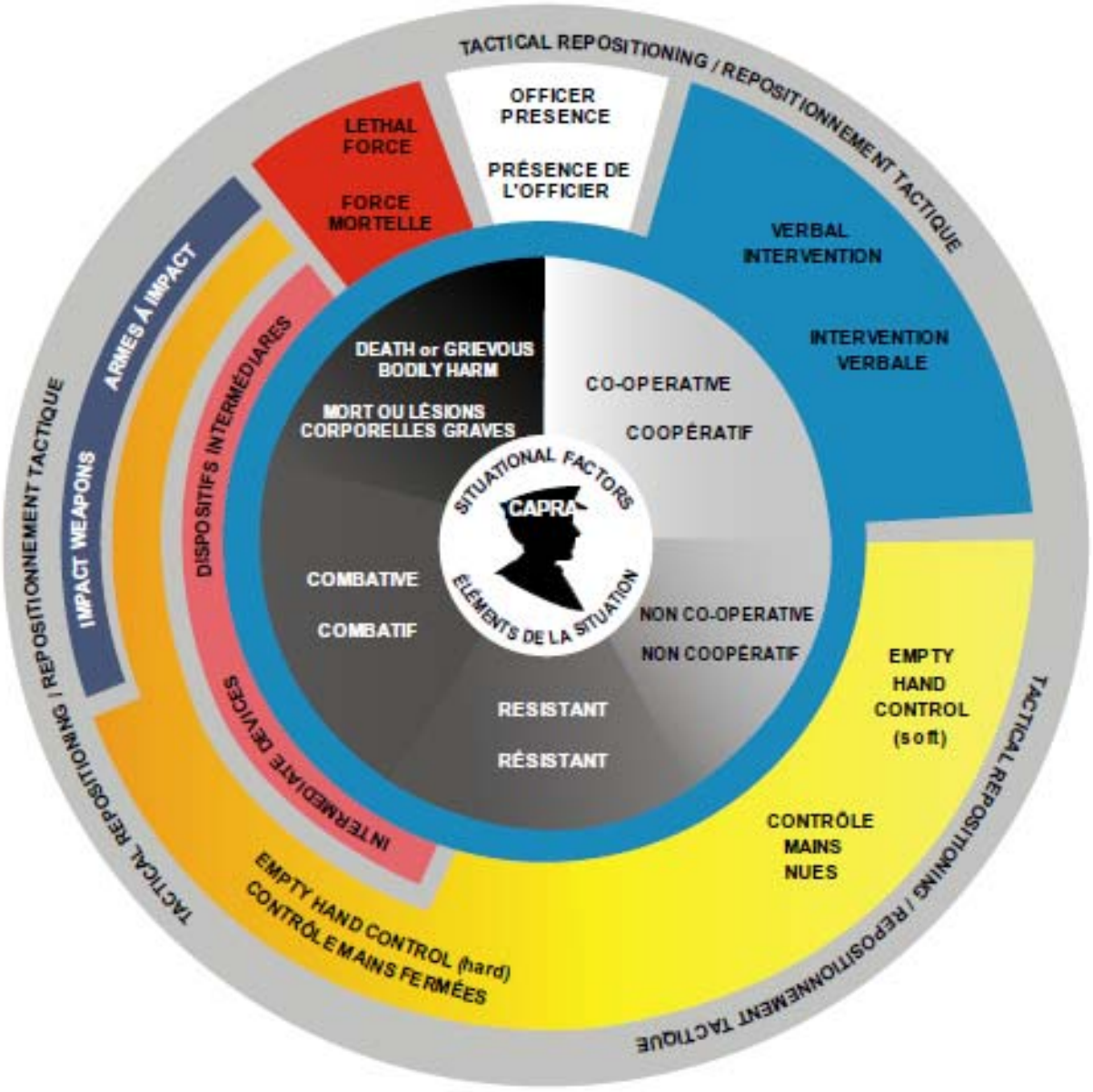
27. Every one is justified in using as much force as is reasonably necessary

(a) to prevent the commission of an offence
(i) for which, if it were committed, the person who com mitted it might be arrested without warrant, and
(ii) that would be likely to cause immediate and serious injury to the person or property of anyone; or

(b) to prevent anything being done that, on reasonable grounds, he believes would, if it were done, be an offence mentioned in paragraph (*a*).

APPENDIX G

Incident Management / Intervention Model Graphical Depiction



(Current at July 21, 2003)

APPENDIX H

Categories of Resistance of Individuals

In the inner portion of the Incident Management/Intervention Model, potential levels of resistance of suspects are noted. The following defines the expected behaviours of individuals displaying each of the levels of resistance included.

1. Cooperative

There is no resistance. The person responds positively to verbal requests, commands or activation of a police vehicle's emergency equipment. The person willingly complies.

2. Non-Cooperative

There is little or no physical resistance. The person does not comply with the officer's request. This can be done through verbal defiance with little or no physical response or failing to pull their vehicle over and stop when an officer activates the police vehicle's emergency equipment. This may include: refusal to leave the scene, failure to follow directions, taunting officers, and advising others to disregard officer's lawful requests.

3. Resistant

The person demonstrates resistance to control by the police officer through behaviours such as pulling away, pushing away or running away. This can include a situation where a police officer activates a police vehicle's emergency equipment and the suspect fails to stop and attempts to evade apprehension by driving evasively.

4. Combative

The person attempts or threatens to apply force to anyone, e.g. punching, kicking, clenching fists with intent to hurt or resists, threats of an assault. In the case of a person operating a vehicle, they attempt to collide with the police vehicle, another vehicle or a pedestrian.

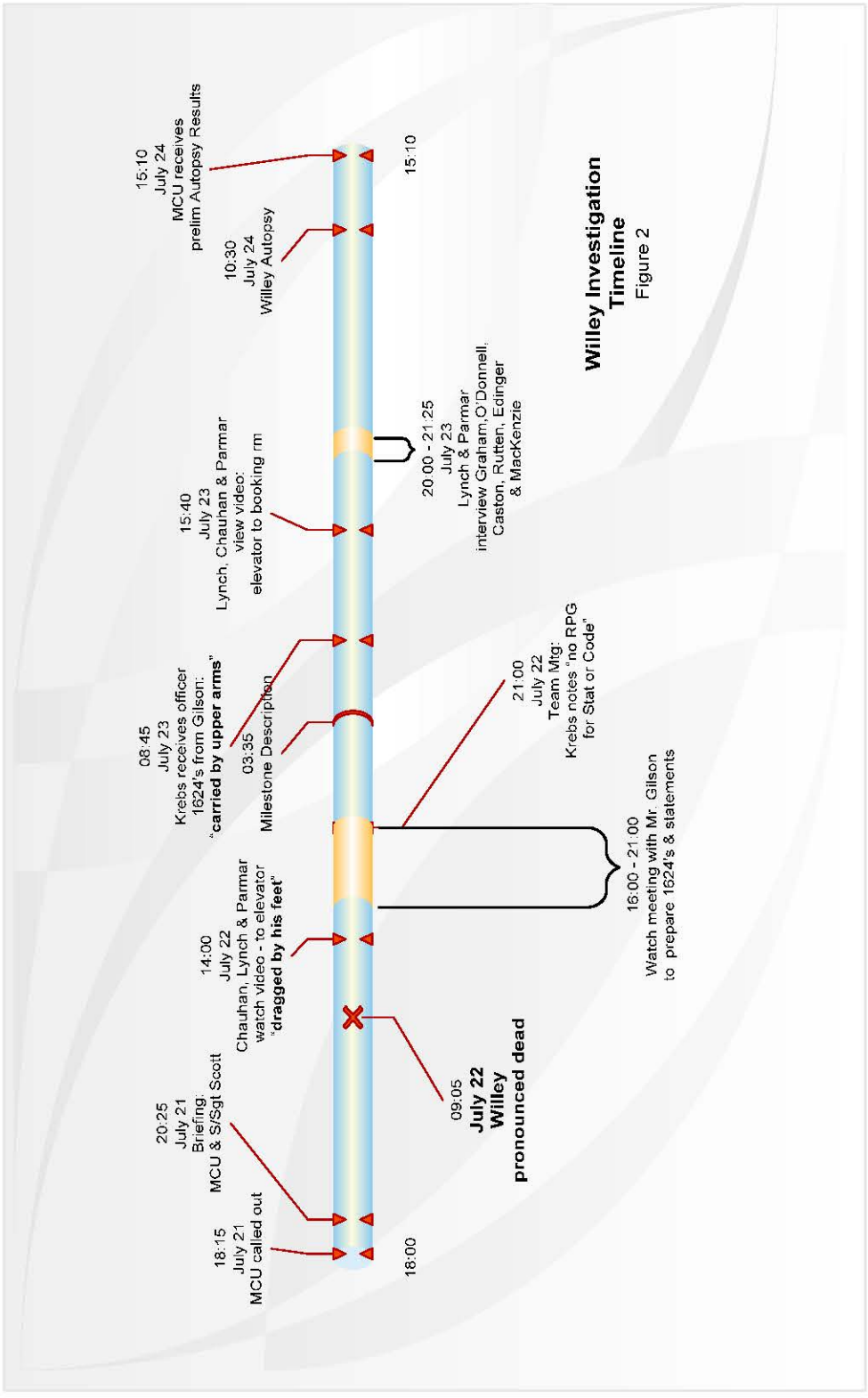
5. Person who shows the potential to cause grievous bodily harm or death

The person acts in a way which would lead the police officer to believe could result in grievous bodily harm or death to the public or the police:

- Knife attack
- Baseball bat
- Use of firearm
- In the case of a person operating a vehicle, the collide with the police vehicle, another vehicle or a pedestrian

APPENDIX I

Investigation Timeline



SCHEDULE 2

RCMP COMMISSIONER'S RESPONSE TO INTERIM REPORT
(COMMISSIONER'S NOTICE)

SCHEDULE 2

Royal Canadian Mounted Police
Commissioner

Gendarmerie royale du Canada
Commissaire

Guided by Integrity, Honesty, Professionalism, Compassion, Respect and Accountability

Les valeurs de la GRC reposent sur l'intégrité, l'honnêteté,
le professionalisme, la compassion, le respect et la responsabilisation

JAN 0 4 2012

Protected "A"

Mr. Ian McPhail, Q.C.
Interim Chair
Commission for Public Complaints
Against the RCMP
P.O. Box 1722, Station "B"
Ottawa, Ontario
K1P 0B3

Dear Mr. McPhail:

I acknowledge receipt of the Commission's Report dated November 4, 2010, on the Public Interest Investigation into a Chair-Initiated Complaint Respecting the In-Custody Death of Mr. Clay Alvin Willey, file reference PC-2009-3397.

I have completed a review of this matter, including the findings and recommendations set out in the Commission's report.

I agree with the finding that the members entered into their interactions with Mr. Willey lawfully and were duty-bound to do so.

I agree with the finding that the force used by Constables John Graham and Kevin Rutten to arrest and apply handcuffs to Mr. Willey was reasonable in the circumstances.

I do not agree with the finding that Constable Rutten's use of oleoresin capsicum (OC) spray during the struggle with Mr. Willey at the parkade was ill-advised. Although there may have been a risk of cross-contamination, Constable Rutten's exercise of judgment was appropriate in the circumstances. The purpose of this public complaint review process, as you have mentioned in your reports in the past, is not to replace our judgment for that of the involved member. Rather, the objective is to determine if the member's actions were reasonable. As you pointed out, the use of the OC spray was not unreasonable in the circumstances, and I agree with your conclusion.

.../2

1200 Vanier Parkway
Ottawa, Ontario
K1A 0R2

1200, promenade Vanier
Ottawa (Ontario)
K1A 0R2

I agree with the finding that it was reasonable for Constable Graham to apply the hog-tie in the circumstances, despite its use having been discontinued by the RCMP. You correctly pointed out that using restraints that are not approved pursuant to RCMP policy does not make their use unreasonable *per se*. Constable Graham used appropriate judgment in using the hog-tie restraint method given the exigent circumstances. I also agree with the finding that the RCMP failed to implement its change in policy in a timely manner with respect to the discontinued use of the hog-tie and approved use of the RIPP Hobble.

I generally support the recommendation that the RCMP develop and communicate to members clear protocols on the use of restraints and the prohibition of the hog-tie, the modified hog-tie and choke-holds. Although I do not agree with your understanding of the hog-tie restraint method (and in particular your position that there is a restraint method that may be described as a "modified hog-tie"), I agree that clear protocols on the use of restraints are necessary. The RCMP does, in fact, have clear protocols in place. Additionally, the RCMP is currently undertaking an initiative to increase members' awareness of policies and procedures by improving existing mandatory operational skills maintenance training.

I agree with the finding that Constables Graham, Holly Fowler and Rutten utilized an appropriate level of force when effecting the arrest of Mr. Willey on July 21, 2003.

I agree with the findings that Constables Jana Scott and John Edinger failed to secure their firearms upon arrival at the detachment as required by RCMP policy and were not justified in deviating from that policy.

I agree with the finding that it was not an appropriate use of force for Constable Scott to have her firearm drawn at the time of Mr. Willey's removal from the police vehicle.

With respect to your finding that Constables Caston and O'Donnell failed to treat Mr. Willey with the level of decency to be expected from police officers when they removed him from the police vehicle and transported him to the elevator, I acknowledge that the manner in which Mr. Willey was removed from the vehicle and transported to the elevator was problematic. As you acknowledged in your report, Mr. Willey was a difficult subject due to his constant movement and physical resistance. I adopt the opinion of Corporal Gregg Gillis, one of the RCMP's use of force experts, that a better way to have removed Mr. Willey from the vehicle would have been to pull him out by hooking their arms under his shoulders to allow for better control of his upper body and head.

.../3

I agree with the finding that the simultaneous use of the conducted energy weapon (CEW) by Constables Caston and O'Donnell was unreasonable, unnecessary and excessive in the circumstances. As you acknowledged in your report, current RCMP policy on the use of the CEW recognizes that multiple deployments of the CEW may be hazardous to a subject. Furthermore, the policy now provides that a member must only use the CEW when a subject is causing bodily harm, or when the member believes, on reasonable grounds, that the subject will imminently cause bodily harm as determined by the member's assessment of the totality of the circumstances.

I agree with the finding that Constables Caston and O'Donnell failed to adequately document their use of the CEW in a timely manner.

I agree with the finding that Constable Graham failed to obtain medical assistance for Mr. Willey in a timely manner. I also agree that, having reasonably concluded that it was a safety issue to bring Mr. Willey to the hospital, it would have been more appropriate for Constable Graham to have arranged for an ambulance to meet the members and Mr. Willey at the Prince George Detachment. While I generally conclude that RCMP members ought to accept responsibility for decisions made with respect to the timing of making arrangements for medical assistance to arrive, it is important to also note that the actions of the involved members in this particular case did not contribute directly or indirectly to Mr. Willey's cause of death, according to the evidence.

I agree with the finding that the RCMP failed to communicate all relevant information about Mr. Willey and his arrest to the ambulance attendants.

Although this incident occurred several years ago and much has been accomplished by the RCMP in terms of improvements made to policies and training of members, I support your recommendation that the Officer in Charge of the Prince George Detachment should take steps to ensure that all members are cognizant of the need to provide all relevant information to medical personnel. I will direct that such steps be taken.

I agree with the finding that the Major Crime Unit (MCU) was deployed to investigate Mr. Willey's arrest and subsequent death in a timely manner and in accordance with RCMP policy.

I agree with the finding that none of the members of the investigative team had a substantial connection to the members involved in this incident.

.../4

I agree with the finding that the scene of Mr. Willey's arrest was not properly secured prior to the arrival of the North District MCU investigation team.

I agree with the finding that members of the Forensic Identification Section attended and processed the scene of the arrest in a timely manner.

I agree with the finding that the MCU investigative team erred in not having the police vehicle, used to transport Mr. Willey, examined prior to being cleaned.

I agree with the finding that the MCU investigative team should have collected Constable Rutten's footwear as potential evidence.

I agree with the finding that the MCU investigative team failed to recognize that a piece of evidence (Mr. Willey's cell phone) had been lost.

I agree with the finding that all of the relevant witnesses were located and interviewed in a timely manner.

I agree with the finding that the investigators failed to obtain at least preliminary accounts from the involved members in a timely manner. As you acknowledged in your report, the RCMP did not have a clear policy in place at the time that would have provided members with appropriate guidance with respect to their obligations to provide a timely preliminary account of the event. I share your opinion that it may be that the lack of such a policy at the time of the incident resulted in the members' failure to provide timely accounts of the event and the failure of investigators to request more timely accounts. I acknowledge your reason for not making a recommendation in relation to this finding, namely, that the RCMP has implemented a policy that addresses this issue.

I agree with the finding that the MCU investigators failed to adequately question the members involved in this incident with respect to their use of force.

You pointed out in your report that none of the procedural errors or oversights made in the course of the MCU investigation would necessarily be determinative or change the ultimate conclusions of the investigation, and I support this assertion. The Major Case Management model as it existed in 2003 was under-resourced and you accepted that this may have accounted for some of the errors made.

I agree with the finding that an expert on use of force should have been identified earlier on during the investigation and a report prepared, the opinion considered by investigators and then forwarded to Crown counsel. I support your recommendation that, where the RCMP investigates itself in situations where force is used and the subject suffers a serious injury or dies, a use of force report would be required prior to review by Crown counsel. The RCMP meets this recommendation as a result of the implementation of the Subject Behaviour/Officer Response Reporting policy.

With respect to the finding that neither the criminal nor conduct aspects of the police involvement in Mr. Willey's death were adequately investigated or addressed, I generally agree with your view that there was a lack of clarity with respect to the mandates of the MCU investigation and the Independent Officer Review. In particular, it was not clear at the time when the Independent Officer Review was conducted whether or not the MCU investigators would bring forward any conduct issues, and the Independent Officer Review was thought to have the purpose of assessing the members actions against policy and training rather than in the context of professional conduct/discipline.

I support your recommendation that the RCMP should clarify the roles of the investigative and reviewing parties to ensure that both the criminal and conduct aspects of an investigation are adequately addressed. This recommendation is in fact met with the implementation of the RCMP External Investigation or Review policy.

I agree with your finding that there was no unreasonable delay in the RCMP's investigation of Mr. Willey's death and it was completed in a timely manner.

I agree with your finding that the videotapes provided by the RCMP to the Commission were the original videotapes depicting Mr. Willey's detention at the detachment.

I agree with the finding that the frozen video image that would have otherwise shown Mr. Willey's removal from the police vehicle was a result of the video recording system, and not the result of human interference.

I support your recommendation that the RCMP should take steps to ensure that any video footage is made available in its entirety and in a viewable format to the coroner's office in the case of an in-custody death and is retained as part of the investigation record. This recommendation has in fact been implemented.

.../6

As a final matter, I acknowledge that any involved members who appeared to have engaged in misconduct cannot be the subject of a formal disciplinary process to determine whether the Code of Conduct was in fact breached, as the limitation period under the *Royal Canadian Mounted Police Act* has expired. However, I do have the option of directing that other formal steps be taken to identify areas where the members who interacted with Mr. Willey fell short of their professional performance, as well as outlining remedial action to address those deficiencies. I will, in fact, issue such a direction.

I would like to thank you for your report and your ongoing work, which will inform our continuing efforts to ensure the RCMP has in place appropriate policies, procedures and practices.

Yours sincerely,

Bob Paulson
Commissioner

www.cpc-cpp.gc.ca