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

JAN 04 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.

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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 Rутten 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.

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.

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.

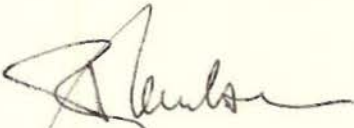
I agree with the finding that the frozen video image that would have otherwise shown Mr. Willey's removal from the police vehicle was a result of the video recording system, and not the result of human interference.

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.

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