Commission for Public Complaints Against the Royal Canadian Mounted Police

Commission des plaintes du public contre la Gendarmerie royale du Canada

Report Following a Public Interest Investigation into a Chair-Initiated Complaint Respecting the Death in RCMP Custody of Mr. Robert Dziekanski

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Executive Summary

December 8, 2009

Canada

EXECUTIVE SUMMARY

BACKGROUND

Mr. Robert Dziekanski died while in the custody of members of the Royal Canadian Mounted Police (RCMP) in the early morning hours of October 14, 2007, in the international arrivals area of the Vancouver International Airport (YVR). The circumstances leading to the death of Mr. Dziekanski have resulted in great pain and sorrow for his family, and in great public interest and concern.

The Commission for Public Complaints Against the RCMP (CPC or Commission) first became engaged in the YVR incident on October 15, 2007, when it deployed an independent observer to the RCMP's criminal investigation into events surrounding the death of Mr. Dziekanski. On November 8, 2007, as Chair of the Commission, I initiated a complaint to delve into the two aspects of the incident which are within the jurisdiction of the Commission, those being the appropriateness of the response by the RCMP to the complaints concerning Mr. Dziekanski's behaviour at YVR, and the police investigation of the death of Mr. Dziekanski.

A third element to the investigation was later added to include a complaint by the British Columbia Civil Liberties Association (BCCLA) pertaining to the "lack of accuracy of information provided to the media and the failure of the RCMP to return the video taken by Mr. Pritchard in a timely manner."

On October 15, 2009 I delivered my report following a public interest investigation and Interim Report to the Commissioner of the RCMP.

KEY CONCLUSIONS FROM THE COMMISSION'S PUBLIC INTEREST INVESTIGATION AND INTERIM REPORT

Overall, I found that the conduct of the responding members fell short of that expected of members of the RCMP. The members demonstrated no meaningful attempt to de-escalate the situation, nor did they approach the situation with a measured, coordinated and appropriate response. The failure of the senior member to take control of the scene, communicate with and direct the more junior and inexperienced members negatively manifested itself throughout the interaction with Mr. Dziekanski.

I do not accept the version of events as presented by the four responding RCMP members. The statements provided by the members are sparse in terms of detail of the events and the thought processes of the members as events unfolded. When tracked against the witness video, the recollections of the members fall short of a credible statement of the events as they actually unfolded. The fact that the members met together prior to providing statements causes me to further question their versions of events.

An issue inextricably linked to the incident is the use of a conducted energy weapon (CEW), also known as a TASER®, by an RCMP member during the arrest of Mr. Dziekanski. The CEW is a prohibited firearm pursuant to the regulations under the *Criminal Code* of Canada.[1] Debate pertaining to the overall appropriateness of the use of CEWs by police had been ongoing for some time prior to the YVR incident (and has been previously commented on by the Commission as indicated below), but this particular use of a CEW focused considerable attention and scrutiny on appropriate CEW usage and the nature of the CEW as a weapon.

Overall, while I found that the IHIT investigation was unbiased, I did find a number of issues involved in the IHIT investigative processes. I also found issues with the RCMP's media releases related to this incident. It is essential that the RCMP develop a media and communications strategy specifically for in-custody death investigations that recognizes the need for regular, meaningful and timely updates to the media and to the public. In addition, the media and communications strategy should include a publicly available general investigative outline of the steps to be taken and the anticipated timeline for each step.

THE COMMISSION'S FINDINGS AND RECOMMENDATIONS

As a result of my investigation, I made a number of findings and recommendations that I believe will assist the RCMP in enacting/reviewing policies and shape training to ensure that a tragic situation such as this is not repeated.

Findings

1. **Finding**
   The RCMP members involved in the arrest of Mr. Dziekanski were in the lawful execution of their respective duties and were acting under appropriate legal authority.

2. **Finding**
   In light of the information possessed by the RCMP members responding, the decision to approach Mr. Dziekanski to deal with the complaints was not unreasonable. At any point a member of the travelling public or an employee at YVR could have happened upon Mr. Dziekanski. As evidenced by the multiple calls to 911, it was incumbent upon the RCMP members to ensure a safe environment for the public and employees using the airport facility and to halt the disturbance being caused by Mr. Dziekanski.

[1] S.2 & Schedule 1, Regulations Prescribing Certain Firearms and other Weapons, Components and Parts of Weapons, Accessories, Cartridge Magazines, Ammunition and Projectiles as Prohibited or Restricted, SOR/98-462.

3. **Finding**
To ensure a coordinated approach to Mr. Dziekanski, Corporal Robinson should have taken control and directed the other responding members to ensure that each was aware of the intended response and to ensure that each communicated with the others as the events unfolded.

4. **Finding**
Prior to deploying the CEW, Constable Millington should have issued the required warning/challenge to Mr. Dziekanski as required by RCMP policy, notwithstanding the fact that Mr. Dziekanski appeared not to understand the English language.

5. **Finding**
Because no significant attempts were made by the RCMP members present to communicate with Mr. Dziekanski, to obtain clarification of information pertaining to Mr. Dziekanski's situation, or to communicate among themselves, deployment of the CEW by Constable Millington was premature and was not appropriate in the circumstances.

6. **Finding**
Constable Millington cycled the CEW multiple times against Mr. Dziekanski when those subsequent cycles were not known by him to be necessary for the control of Mr. Dziekanski.

7. **Finding**
The multiple cycles of the CEW against Mr. Dziekanski when no significant effort was made to determine the effect of the CEW on Mr. Dziekanski was an inappropriate use of the CEW.

8. **Finding**
Corporal Robinson did not adequately monitor Mr. Dziekanski's breathing and heart rate.

9. **Finding**
Because Corporal Robinson did not know the qualifications of Mr. Enchelmaier, he should not have allowed him to provide first aid or actively monitor Mr. Dziekanski's condition. That task should have been performed by the RCMP members themselves. Corporal Robinson, therefore, failed to provide adequate medical care to Mr. Dziekanski.

10. **Finding**
The handcuffs should have been removed from Mr. Dziekanski when the members recognized that he was unconscious and in distress and no immediate threat to the members was perceived. At a minimum, they should have been removed immediately upon the initial request of medical personnel.

11. Finding

The failure of Corporal Robinson to take control of the scene, communicate with and direct the more junior and inexperienced members negatively manifested itself throughout the interaction with Mr. Dziekanski.

12. Finding

I do not accept as accurate any of the versions of events as presented by the involved members because I find considerable and significant discrepancies in the detail and accuracy of the recollections of the members when compared against the otherwise uncontroverted video evidence. In their statements, the members indicated in responses to numerous questions that they could not recall the detail of the events as they unfolded. The fact that the members met together and with the SRR prior to providing statements causes me to question further their versions of events.

13. Finding

The conduct of the responding members fell short of that expected of members of the RCMP by the Canadian public and by RCMP policies. The members demonstrated no meaningful attempt to de-escalate the situation, nor did they approach the situation with a measured, coordinated and appropriate response.

14. Finding

The members failed to adequately comply with their training in CAPRA and IM/IM to assess the behaviour of Mr. Dziekanski, and therefore the risk posed by him. As a result, the level of intervention went beyond what was necessary and acceptable, contrary to the RCMP's IM/IM and CAPRA model.

15. Finding

Because the RCMP positions the CEW as an intermediate weapon and trains its members that it is appropriate to use the CEW in response to low levels of threat because it is a relatively less harmful means of controlling a subject, the responding members did not fully appreciate the nature of the CEW as a weapon and it was resorted to too early.

16. Finding

Although IHIT did engage the services of a use of force expert, that expert was not provided with adequate direction in terms of the questions to be considered, the scope of his work or the terms of reference he was to consider.

17. Finding

Corporal Robinson, as an involved member, should not have been allowed to attend the IHIT briefing held at the Richmond Detachment on October 14, 2007. Sergeant Attew failed to ensure that only appropriate RCMP members were present during the briefing.

18. Finding

The responding RCMP members meeting alone at the YVR sub-detachment office following the death of Mr. Dziekanski was inappropriate.

19. Finding

An SRR should not have been permitted to meet alone with Constable Millington prior to the IHIT investigator.

20. Finding

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 versions of events and the video, it would have been appropriate to provide the responding members with an opportunity to view the Pritchard video prior to taking further statements from them.

21. Finding

The responding members did not keep adequate notes of the incident involving Mr. Dziekanski.

22. Finding

No bias or partiality toward the involved RCMP members was present in the IHIT investigation of the death of Mr. Dziekanski.

23. Finding

The RCMP should have released certain information to the media which would have served to clarify information pertaining to the death of Mr. Dziekanski and correct erroneous information previously provided without compromising the IHIT investigation.

Recommendations

1. Recommendation

The RCMP should review the CEW quality assessment program as currently in effect and consider whether it should be enhanced to ensure that a high degree of confidence may be placed in the performance of in-service CEWs.

2. Recommendation

The RCMP should continue to be involved in and stay abreast of current independent research on the use and effects of the CEW.

3. Recommendation

Notwithstanding the fact that the RCMP has (as of January 2009) amended its policy such that the use of the CEW is to be used in response to a threat to officer or public safety as determined by a member's assessment of the totality of the circumstances being encountered, the RCMP should clarify for its members and the public what the appropriate circumstances for using the CEW are and what threat threshold will be utilized to assess the appropriateness of such use.

4. **Recommendation**
   The RCMP should consider a review of its training to ensure that its members are well versed in the potentially dangerous nature of the weapon and to ensure that training provided to members assists them in appropriately assessing the circumstances in which deployment of the CEW is justified, bearing in mind the degree of pain inflicted on the subject during the CEW deployment and the potential outcome of such deployment.

5. **Recommendation**
   The RCMP should consider designing and implementing training for its members in techniques to communicate with persons who cannot meaningfully communicate with them.

6. **Recommendation**
   The RCMP should:
   1. Amend its Conducted Energy Weapon (CEW) Usage Reporting Form (Form 3996), to require that information concerning a spark test be captured as part of the CEW usage reporting process (or include such requirement in the forthcoming Subject Behaviour/Officer Response data base); and
   2. Edit its Operational policy to emphasize the importance of the spark test and clearly indicate that the spark test is mandatory to confirm proper functioning of the CEW.

7. **Recommendation**
   RCMP detachment familiarization procedures should include a detailed review of available medical facilities and equipment.

8. **Recommendation**
   The RCMP should review its processes and criteria with respect to the initiation of an internal investigation into the conduct of its members to ensure consistency of application across the country.

9. **Recommendation**
   I reiterate my recommendation from my report on the Police Investigating Police (August 2009) that all RCMP member investigations involving death, serious injury or sexual assault should be referred to an external police force or provincial criminal investigation body for investigation. There should be no RCMP involvement in the investigation. If, however, the RCMP continues to investigate such matters, then I recommend that the RCMP implement clear policy directives that all investigations in which death or serious bodily injury are involved and which involve RCMP members investigating other police officers will be considered criminal in nature until demonstrated not to be.

10. **Recommendation**
    If the protocol of SRR attendance is to continue, the RCMP should formalize the role of the SRR to provide clear policy and guidance to ensure that the SRR knows the bounds of his or her involvement and the required protocols

with respect to such attendance, and that in all such cases the SRR not meet alone with a subject member in advance of being interviewed by an investigator.

11. Recommendation

I reiterate my recommendation in the Ian Bush decision (November 2007) that *[t]he RCMP develop a policy that dictates the requirement, timeliness and use of the duty to account that members are obliged to provide.*

12. Recommendation

The RCMP should review its operational policies and procedures to ensure that, particularly in serious cases in which members investigate the actions of other members, processes are available to enable investigator awareness of the nature and depth of detail required during interviews.

13. Recommendation

The RCMP should take steps to ensure that members are aware of the importance of note taking, and that supervisors should be encouraged to regularly review the notes taken by their subordinates to ensure the quality of such documentation.

14. Recommendation

Given the proliferation of recording devices, it is anticipated that incidents in which RCMP members will seek to obtain private video or audio recordings will potentially occur more frequently in the future. Whether the police seize a video or audio recording of an event or obtain it on consent from a member of the public, the police must know and advise the public of the authority under which the video or audio recording is obtained. I recommend that the RCMP provide clarification for members with respect to obtaining video or audio recordings of an event.

15. Recommendation

I reiterate my recommendation in the Ian Bush decision that *[t]he RCMP develop a media and communications strategy specifically for police-involved shooting investigations that recognizes the need for regular, meaningful and timely updates to the media and to the public. In addition, the media and communications strategy should include a publicly available general investigative outline of the steps to be taken and the anticipated timeline for each step.* I also expand my recommendation to cover all in-custody death investigations.

16. Recommendation

The RCMP should immediately conduct a review of its policies and training regimen to ensure that members are adequately trained with respect to recognizing the risks inherent in, and signs of, positional asphyxia and in taking steps to mitigate those risks.

THE COMMISSION'S PUBLIC INTEREST INVESTIGATION AND INTERIM REPORT

The facts giving rise to the incident are well known to the public. After arriving in Vancouver from Poland on October 13, 2007, Mr. Dziekanski remained inside the international arrivals secure area of YVR for many hours. In the early hours of October 14, Mr. Dziekanski began to act irrationally and damaged a computer and a chair, both of which were the property of YVR. A series of 911 complaints of a man acting erratically in the international arrivals area of the airport caused the RCMP to respond. After a very brief encounter, a conducted energy weapon (CEW) was deployed against Mr. Dziekanski and he was taken into custody. He died shortly thereafter.

The formal parameters of the investigation were as follows:

1. Whether the RCMP officers involved in the events of October 14, 2007, from the moment of initial contact until Mr. Dziekanski's subsequent death, complied with all appropriate policies, procedures, guidelines and statutory requirements for the arrest and treatment of persons taken into custody, including any RCMP directives or guidance related to the handling of persons who cannot communicate in either of Canada's official languages, and whether such policies, procedures and guidelines are adequate.

2. Whether the RCMP officers involved in the criminal investigation of the members involved in the events of October 14, 2007 complied with the RCMP policies, procedures, guidelines and statutory requirements for the conduct of such an investigation and whether such policies, procedures and guidelines are adequate and, further, whether such investigation was carried out in an adequate and timely fashion.

3a. On November 13, 2007, the British Columbia Civil Liberties Association (BCCLA) initiated a public complaint pursuant to Part VII of the *RCMP Act*, pertaining to the lack of accuracy of information provided to the media and the failure of the RCMP to return the video taken by Mr. Pritchard in a timely manner. These actions were characterized by the BCCLA as violations of RCMP policy and professional misconduct on the part of the involved RCMP members.

3b. The BCCLA was not satisfied with the RCMP's subsequent investigation into its complaint. In a letter received from the BCCLA dated March 19, 2009, subsequent to the Chair's decision to also address issues involving RCMP media releases, the Commission was requested to review the RCMP investigation into the BCCLA complaint pertaining to RCMP media releases. The Chair acceded to this request and the review has been incorporated into the Interim Report.

REPORT HIGHLIGHTS

While the specific findings and recommendations made in my Report are set out above, the following are highlights of the Report:

Allegation 1: Propriety of Member Conduct re Interaction with Mr. Dziekanski

RCMP's First Interaction with Mr. Dziekanski

Four RCMP members were on duty at YVR at the time of the incident:

> Corporal Benjamin Robinson was the most senior member present and was also the shift supervisor. At the time of the incident, Corporal Robinson had approximately 11 years of police service.
>
> Constable Kwesi Millington had just under two and a half years service, and was the only one of the four who was equipped with a CEW that evening (Model X26E).
>
> Constable Gerry Rundel had approximately two years of service and had been posted at YVR since approximately October 2006.
>
> Constable Bill Bentley had approximately one and a half years of service. He began working at YVR in September 2007.

As a result of a series of 911 calls, the four RCMP members responded to complaints of a man (now known to be Mr. Dziekanski) acting erratically in the international arrivals area. By the time they reached the area, they had been advised that a male of approximately 50 years of age (Mr. Dziekanski was later found to be 40 years of age), who was thought to be intoxicated (later found not to be true), was acting erratically, throwing luggage around and throwing chairs through windows (later found not to be true). The male was further described as having dark hair and was wearing a white jacket.

Upon their arrival, YVR security pointed out Mr. Dziekanski as the person involved in the erratic behaviour and indicated that he did not speak English. As the members entered the secure area, they would have been able to view the broken computer on the floor as well a small table broken against the glass (no glass was actually broken). The video taken by Mr. Paul Pritchard and witness statements confirm that upon arrival, the RCMP members received basic information from YVR Security and other witnesses as they continued to walk toward Mr. Dziekanski and hopped over a small retaining barrier.

The RCMP members had no way of knowing that Mr. Dziekanski had been travelling for many hours, that he apparently had consumed no food and had very little fluids to drink, nor could they be expected to gauge the level of Mr. Dziekanski's state of mind or his possible frustration at not meeting his

mother as he had no doubt anticipated would happen when he arrived in Canada.

In light of the information possessed by the RCMP members responding, the decision to approach Mr. Dziekanski to deal with the complaints was not unreasonable. As evidenced by the multiple calls to 911, it was incumbent upon the RCMP members to ensure a safe environment for the public and employees using the airport facility and to halt the disturbance being caused by Mr. Dziekanski. The members were in the lawful execution of their respective duties and were acting under appropriate legal authority.

However, I have noted that none of the members stopped to meaningfully obtain details or confirm from witnesses present the information received via police radio with respect to the nature of Mr. Dziekanski's actions (such as the allegation that Mr. Dziekanski had thrown furniture through a window—which was later found not to be true—or the degree of violence involved).

Decision to Deploy the CEW

Within twenty-five seconds after the interaction began, a decision was made by Constable Millington to deploy the CEW carried by him during that shift. Following the deployment and multiple cycling of the CEW on Mr. Dziekanski and a scuffle involving all four RCMP members, Mr. Dziekanski was subdued and handcuffed. He died shortly thereafter while under the control of the RCMP members.

I am satisfied that the responding RCMP members did not intend to cause death or harm to Mr. Dziekanski. Through my investigation, however, I have noted a number of deficiencies in the manner in which the RCMP members responded to the complaints concerning Mr. Dziekanski.

Although the RCMP members were trained that the CEW is a less lethal means of control and that its use is a means to avoid injury to police officers and to the subject of the CEW deployment, and as per the CAPRA model of problem solving (the model used by the RCMP to train its members in the analysis of risk during police response situations), it was incumbent on the responding members to exercise judgement prior to deploying the CEW. Time was available for the members to confirm events with witnesses, consider tactical repositioning or to attempt to de-escalate the situation, such as by continuing to use hand gestures and presenting a non-threatening demeanour to Mr. Dziekanski. Unfortunately, the CEW was discharged before any meaningful de-escalation was attempted.

Various operational rationales were advanced as to why Constable Millington could not take additional time to assess the situation. These include the facts that Mr. Dziekanski had in his hand a weapon (an open stapler) and that the target Mr. Dziekanski presented to Constable Millington might be lost if Mr. Dziekanski lunged at one of the responding members. I find it difficult to accept these as being realistic in the circumstances.

The Pritchard video, when mapped against the CEW download report shows that Mr. Dziekanski had fallen to the floor and was writhing in pain at the termination of the first five-second CEW deployment. This begs the question of why additional CEW cycles were necessary. Following the first CEW discharge, the members can be seen standing around Mr. Dziekanski. After a one-second pause, the CEW is cycled a second time for five seconds. It is not until the termination of the second deployment that Corporal Robinson can be seen as the first member to move in to subdue Mr. Dziekanski. At this point, Mr. Dziekanski had been subjected to a total of approximately 10 seconds of intense pain with no attempt made by police to restrain him.

After the second deployment, the responding RCMP members began to struggle with Mr. Dziekanski. Instead of waiting to determine whether a third deployment was necessary, Constable Millington, after a two-second delay, again deployed the CEW for a five-second cycle.

On completion of the third deployment in probe mode, Constable Millington removed the cartridge from the CEW and, four seconds later, deployed the CEW in push stun mode against Mr. Dziekanski's back for nine seconds. After a one-second delay, Constable Millington again deployed the CEW against Mr. Dziekanski in push stun mode for a further six seconds.

No meaningful effort was made to de-escalate the situation (although I recognize that had such attempts been made, the use of the CEW may ultimately have been required). The speed with which the decision was taken to deploy the CEW was not appropriate in these circumstances. I also found that the decision to cycle the CEW multiple times against Mr. Dziekanski without taking time to determine the effect of the CEW on him was inappropriate and not in keeping with using the least amount of force necessary to effect an arrest.

I appreciate that the events as they unfolded in real time were stressful for all involved and I do not expect police officers to engage in communal decisions when the window to do so is very short and the circumstances dictate an immediate response. That said, Mr. Dziekanski was fully surrounded in a confined space. Had Constable Millington taken even a few more seconds to take stock of the available options, the dynamic may have changed and resulted in a much different outcome.

Three of the four responding RCMP members had an average of two years of police service. The senior member (Corporal Robinson) did not take charge of the response to ensure that the actions taken by the responding RCMP members were appropriate. Notwithstanding that events occurred quickly, compounding this failure to take control was the fact that the members did not communicate with each other as the events unfolded.

CEW Challenge and Communications with Mr. Dziekanski

RCMP Operational policy in effect at the time required that, when possible, members are to give the warning *Police, stop or you will be hit with 50,000 volts of electricity!* This warning, or challenge as it is called in RCMP policy, was not given by Constable Millington. He was not asked by the RCMP's investigators about the failure to warn when he gave his statements post-event. However, in his CEW Usage Report (Form 3996), Constable Millington indicated that the warning was not given. The reason cited was:

> *Member told male to stop moving and put hands on desk nearby. The male did not understand English so verbal communication was difficult.*

During his testimony at the Braidwood Inquiry, Constable Millington stated that he felt he did not have time to issue the challenge to Mr. Dziekanski before he deployed the CEW.

Having viewed the video of the event, I see no reason why the warning could not have been given. The members had surrounded Mr. Dziekanski by that time and although one senses from the video that steps to address the situation were about to be taken imminently, Constable Millington had time to issue the challenge prior to discharging the CEW.

At a minimum, issuing the challenge would have drawn Mr. Dziekanski's attention to the fact that a weapon was pointed at him and would have confirmed to Constable Millington and the others present that Mr. Dziekanski was aware of the presence of a weapon (whether or not he appreciated it was a CEW). From my viewing of the Pritchard video, I do not believe that Mr. Dziekanski actually looked at Constable Millington before the CEW was deployed. The understanding that a weapon was pointed at him may have caused the situation to de-escalate, thereby avoiding the necessity of deployment. Conversely, had the CEW been ultimately necessary, at a minimum other means of resolution would have been attempted.

I found that prior to deploying the CEW, Constable Millington should have issued the required warning/challenge to Mr. Dziekanski as required by RCMP policy, notwithstanding the fact that Mr. Dziekanski appeared not to understand the English language. I recommended that the RCMP consider designing and implementing training for its members in techniques to communicate with persons who cannot verbally communicate with them.

Post CEW Deployment

Following the deployment of the CEW and arrest of Mr. Dziekanski, the RCMP members did not provide adequate monitoring of Mr. Dziekanski. Although the senior RCMP member on duty did take Mr. Dziekanski's pulse and monitor his breathing, he did not do so on a regular basis. Rather, a YVR Security member took the lead in monitoring Mr. Dziekanski's vital signs.

Members of the RCMP had arrested and placed Mr. Dziekanski in handcuffs and, given the duty of care owed to persons in custody, it was their responsibility to physically monitor and see to the welfare of Mr. Dziekanski. It should have been RCMP members, therefore, who actually monitored Mr. Dziekanski pending the arrival of qualified medical personnel. In addition, because the RCMP did not know the qualifications of the YVR Security member, they should not have allowed him to provide first aid or actively monitor Mr. Dziekanski's condition.

The initial call from the involved police officers for medical support was Code 1 (routine response), but it was quickly upgraded to Code 3 (emergency response) when Mr. Dziekanski became unconscious. According to witness statements and the statements of the responding members, prior to the arrival of fire and ambulance personnel, Mr. Dziekanski was turning blue. That Mr. Dziekanski was in distress should have been increasingly obvious to the attending members.

Richmond Fire personnel indicated that they requested several times that the handcuffs be removed from Mr. Dziekanski, as did BC Ambulance personnel upon their arrival. The reason cited by RCMP members for not removing the handcuffs was a concern for the safety of those present in the event Mr. Dziekanski was being deceptive or regained consciousness and became combative. However, I am aware of no evidence to support the suspicion that Mr. Dziekanski was feigning or being deceptive. Therefore, I found that the handcuffs should have been removed from Mr. Dziekanski when the members recognized that he was unconscious and in distress and no immediate threat to the members was perceived.

Adequacy of RCMP Policy

The public expects that both first responders and subsequent investigators will receive sufficient training and instruction to ensure that they are aware of and comply with applicable legislation and policies. The public also expects the guiding documentation and policy to be reasonable. As such, the Report also looks at the adequacy of the RCMP policy that was in place at the time of the incident.

Appropriate Use of the CEW

The CEW is a prohibited firearm under the *Criminal Code*. 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 it is not justifiable nor in accordance with RCMP policy.

I question whether police officers appreciate the nature and quality of the pain being dispensed when deploying a CEW. In this case, the members appear not to have contemplated whether the application of a pain compliance technique

was justified in this situation. At the time of Mr. Dziekanski's death, the RCMP's Incident Management Intervention Model (the framework by which RCMP officers assess and manage risk through justifiable and reasonable intervention) categorized the CEW as an intermediate level use of force option in the same genre as OC spray.

The RCMP appears to accept the proposition that the CEW is a less harmful and reliable means of controlling individuals who fall within the parameters of acceptable CEW usage. In support of this position, the RCMP often relies on studies funded by Taser International which support this proposition. The Commission has noted various issues with Taser International-funded methodological research.

Given the injuries that have occurred subsequent to deployments of the CEW, the onus of demonstrating that the CEW is a viable response in the particular circumstances of its use must rest with the police. Justification of its use must include an appreciation of the nature of the CEW, i.e. that the level of pain inflicted and the potential for serious bodily harm or death to the recipient was appropriate and necessary within the confines of a specific set of circumstances.

Notwithstanding the fact that the RCMP has (as of January 2009) amended its policy such that the use of the CEW is to be used in response to a threat to officer or public safety as determined by a member's assessment of the totality of the circumstances being encountered, the RCMP should clarify for its members and the public what the appropriate circumstances for using the CEW are and what threat threshold will be utilized to assess the appropriateness of such use.

The RCMP should also consider a review of its training to ensure that its members are well versed in the potentially dangerous nature of the weapon and to ensure that training provided to members assists them in appropriately assessing the circumstances in which deployment of the CEW is justified, bearing in mind the degree of pain inflicted on the subject during the CEW deployment and the potential outcome of such deployment.

Overarching the foregoing is the issue of quality control. Although CEWs have currently been subjected to independent testing as part of an ongoing internal RCMP audit, I found the RCMP process to be an inadequate level of quality control. Therefore, I recommended that the RCMP review the CEW quality assessment program as currently in effect and consider whether it should be enhanced to ensure that a high degree of confidence may be placed in the performance of in-service CEWs.

Positional Asphyxia

Two pathologists made reference to Mr. Dziekanski being placed in a prone position while being restrained and the possibility that this position, coupled with a state of high agitation, can lead to death. I note from my review of the video of the arrest of Mr. Dziekanski, that Corporal Robinson is seen to be apparently

placing weight on Mr. Dziekanski's upper body for approximately 40 seconds during the struggle, while Mr. Dziekanski was in the prone position.

While not conclusive or determinative of the cause of death, and based on the comments of the pathologists in this case, it is my belief that positional asphyxia may occur independent of other contributing factors such as delirium. The RCMP should immediately conduct a review of its policies and training regimen to ensure that members are adequately trained with respect to recognizing the risks inherent in, and signs of, positional asphyxia and in taking steps to mitigate those risks.

Allegation 2: Propriety of the Investigation

RCMP Investigation

Following the death of Mr. Dziekanski, a homicide investigation was conducted by the Integrated Homicide Investigation Team (IHIT). Within hours of the commencement of the IHIT investigation, a member of my staff was present as an Independent Observer of the investigation. The purpose of the Independent Observer is to monitor the investigation for bias or partiality, but not to assess the veracity of statements or weigh evidence. The Independent Observer, who observed the IHIT investigation for the first weeks of its existence, found no issues to report.

IHIT is responsible for investigating homicides, police involved shootings and in-custody deaths that occur within the Lower Mainland areas policed by the RCMP, Abbotsford, New Westminster and Port Moody police departments. Although the IHIT teams are considered integrated, i.e. investigators from each of the four police agencies participate in IHIT investigations, the team investigating the death of Mr. Dziekanski consisted only of RCMP members.

Authority for Investigation

I am concerned that the nature of the investigation was not apparent to the investigators, i.e. whether they were conducting a criminal investigation or an investigation under the BC *Coroner's Act*. I reiterated my recommendation from my report on the Police Investigating Police (August 2009) that all RCMP member investigations involving death, serious injury or sexual assault should be referred to an external police force or provincial criminal investigation body for investigation. There should be no RCMP involvement in the investigation. If, however, the RCMP continues to investigate such matters, the RCMP should implement clear policy directives that all investigations in which death or serious bodily injury are involved and which involve RCMP members investigating other police officers will be considered criminal in nature until demonstrated not to be.

Presence of Involved Member at IHIT Briefing

On October 14, 2007 an IHIT briefing was held at the Richmond RCMP Detachment. Present were the IHIT investigative team and media relations officers. My investigation revealed that at some point during the briefing, Corporal Robinson, one of the involved members, was present and related to the IHIT members his perception of events.

Corporal Robinson, as an involved member, should not have been permitted to attend the IHIT briefing held at the Richmond Detachment on October 14, 2007. Staff Sergeant (then Sergeant) Attew, the IHIT team commander at that time, stated that he was not aware that Corporal Robinson was one of the four involved members or he would not have allowed Corporal Robinson to attend. The responsibility to ensure that the integrity of the investigation was maintained fell to the senior IHIT member at the briefing. As team commander at the time, that was Staff Sergeant Attew.

Statements from Members and Involvement of the Staff Relations Representative (SRR)

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. According to information before the Commission, many RCMP members are of the view that there exists an unwritten rule that members will provide what amounts to a duty to account statement following an incident. Such statements are at times taken following a meeting between the Staff Relations Representative (SRR)[2] and the member involved.

The requirements of the duty to account statement must be clear to all RCMP members. That is not currently the case within the RCMP nationally. As such, I reiterated the recommendation I made in my report on the death of Ian Bush (November 2007) that the RCMP develop a policy that dictates the requirement, timeliness and use of the duty to account that members are obliged to provide.

One statement taken from one of the responding members was considered by IHIT investigators to be a duty to account statement. This was a statement taken by Corporal D. Brassington from Constable Millington at the sub-detachment office in the hours following the incident. When Corporal Brassington arrived, all of the responding members were together in the sub-office, along with Corporal Ingles, the SRR. Corporal Ingles indicated to Corporal Brassington that he had spoken with Constable Millington.

It appears to me from comments made by Corporal Ingles that, in his view, the role of the SRR is to filter information as between the involved member and the investigators. That is a practice fraught with potential pitfalls. The investigators,

[2] The RCMP is not unionized. SRRs carry out a function akin to a union representative.

particularly in the early stages of an investigation, require facts which are not adulterated or influenced. The investigator is at liberty to conduct the interview of the involved member without the SRR potentially having first discussed the facts of the situation with the member.

In addition to concerns with the presence of the SRR prior to any interview being conducted or statement taken from police witnesses by the investigators, I have concerns with the fact that apparently all of the involved members were together following the death of Mr. Dziekanski to meet with the SRR. Basic investigative practice is for witnesses to be separated to avoid any opportunity for complicity or the appearance of such.

The responding members should not have met alone following the incident, and the SRR should not have been permitted to meet alone with Constable Millington prior to the IHIT investigator. If the protocol of SRR attendance is to continue, the RCMP should formalize the role of the SRR to provide clear policy and guidance to ensure that the SRR knows the bounds of his or her involvement and the required protocols with respect to such attendance, and that in all such cases the SSR not meet alone with a subject member in advance of being interviewed by an investigator.

IHIT Approach to Questioning Members

It is apparent to me that the IHIT investigators did not approach the interviews of the involved members or the civilians with a coordinated set of issues to be covered to ensure that the same areas were canvassed with each person. This is not to suggest that the IHIT investigators should have conducted each interview from the same set of questions, but coordination of the nature of questions to be asked of each witness would have been helpful. The resulting statements do not represent what would be considered a coordinated approach.

My concern is that investigators may have worked in isolation of the details obtained by others and that the coordination of information may have caused necessary questions to go unasked. Consequently, I recommended that the RCMP review its operational policies and procedures to ensure that, particularly in serious cases in which members investigate the actions of other members, processes are available to enable investigator awareness of the nature and depth of detail required during interviews.

It also concerned me that the investigators did not show the Pritchard video to the responding members after realizing that the members' original statements did not align with the video evidence. 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 versions of events and the video, it would have been appropriate to provide the responding members with an opportunity to view the Pritchard video prior to taking further statements from them.

Notes of Responding Members

I reviewed the notes taken by each of the responding members with respect to the interaction with and death of Mr. Dziekanski. I found that the quality, completeness and content were well below the standard expected of police officers. At best, the notes provide a very high level overview of the incident. During his testimony in the Braidwood Inquiry, Staff Sergeant Douglas Wright (the Staff Sergeant in charge of the YVR sub-detachment at the time of the incident) indicated that he urged Corporal Robinson to take "excellent notes" about the incident, but that ultimately those notes were not to his standard.

To be clear, I make a distinction between note taking in the field and the completion of the various reporting forms to be completed by RCMP members. Although RCMP policy requires in some circumstances that computer-based reporting be completed prior to the end of shift, absent adequate field note taking, the reliability of the data used for inclusion in the mandatory reporting documents must be considered suspect. Furthermore, the Commission has reviewed many cases in which the electronic reporting forms are not completed in a timely manner. In such cases, absent comprehensive, contemporaneous notes, the reliability of the written record will be seriously diminished.

The issue of sub-standard note taking has arisen in a number of previous Commission decisions. To date, the Commission has seen no discernable improvement in note taking. The RCMP should take steps to ensure that members are aware of the importance of note taking, and that supervisors should be encouraged to regularly review the notes taken by their subordinates to ensure the quality of such documentation.

Code of Conduct – Internal Investigation

Stemming, but separate from, the IHIT investigation into the death of Mr. Dziekanski, it was open to the RCMP to initiate an internal investigation into the actions of both the responding members and the media relations officers in order to ascertain whether disciplinary action was warranted. Other than a confirmation that no such investigation(s) were commenced, I have received no other information from the RCMP against which to assess the appropriateness of this decision, or whether the issue was canvassed within the RCMP.

Notwithstanding any recommendation I might make at this point with respect to a review of the decision not to conduct such an investigation, the outcome is moot in 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. That one year period has now passed.

In light of the foregoing, I recommended that the RCMP review its processes and criteria with respect to the initiation of an internal investigation into the conduct of its members to ensure consistency of application across the country.

Allegation 3a: Timeliness of the Return of Mr. Pritchard's Video

The video taken by a witness, Mr. Paul Pritchard, at YVR of the incident involving Mr. Dziekanski was purportedly "borrowed" from him by an IHIT investigator on the night of the incident. According to documents filed by Mr. Pritchard during his attempts to recover the video, he was told that the video was to be copied by the RCMP and that it would be returned to him within 48 hours. Mr. Pritchard was subsequently informed that the time of return could be one and a half to over two years (approximately) because it would be used at a Coroner's Inquiry.

Mr. Pritchard initiated legal proceedings to recover his video, which ultimately was returned to him. Given that the video was not initially seized from Mr. Pritchard but was obtained with his consent and acquiescence, the RCMP had no authority to retain the video when Mr. Pritchard asked for its return. If the video was considered to be seized, this fact should have been clearly communicated to Mr. Pritchard. Either way, it was unclear to Mr. Pritchard what the status of his property was.

Given the proliferation of recording devices, it is anticipated that incidents in which RCMP members will seek to obtain private video or audio recordings will potentially occur more frequently in the future. Whether the police seize a video or audio recording of an event or obtain it on consent from a member of the public, the police must know and advise the public of the authority under which the video or audio recording is obtained. I recommended that the RCMP provide clarification for members with respect to obtaining video or audio recordings of an event.

Allegation 3b: Propriety of Media Releases

Information provided to the media by the RCMP, especially in the early days of the investigation, is an issue. I noted a number of examples in which the information provided to the media was incorrect, and known to be so by the RCMP. The RCMP, however, decided not to correct those known errors.

That, in my view, was an error on the part of the RCMP. To the extent that corrections could have been made without compromising the integrity of the investigation, they should have taken place. Correcting relatively straightforward inaccuracies such as the number of members present or the number of times the CEW was cycled would not have compromised the position of the RCMP vis-à-vis any criminal investigation of the events. Failing to do so perpetuates concerns that the police are not conducting a transparent and impartial investigation into its members.

It is essential that the RCMP develop a media and communications strategy specifically for in-custody death investigations that recognizes the need for regular, meaningful and timely updates to the media and to the public. In addition, the media and communications strategy should include a publicly available general investigative outline of the steps to be taken and the anticipated timeline for each step.