COMMISSION FOR PUBLIC COMPLAINTS AGAINST THE RCMP

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

File No.: PC-2009-3397

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THE COMPLAINT

On July 21, 2003, Mr. Clay 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

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