

**COMMISSION FOR PUBLIC COMPLAINTS AGAINST THE RCMP**

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

Complainant

Chair of the Commission for Public  
Complaints Against the RCMP

September 9, 2011

File Nos.: PC-2007-2427  
PC-2007-2624

## **CHAIR'S FINAL REPORT AFTER COMMISSIONER'S NOTICE**

### **Background**

On November 19, 2007, shortly before 3:00 p.m., Mr. Robert Thurston Knipstrom was allegedly involved in a hit and run in Chilliwack, British Columbia. Mr. Knipstrom immediately left the scene and continued on to an equipment rental centre to return a wood chipper he had rented. While he was there, he began displaying odd behaviour, including going up and down the stairs that led to the second floor where female staff worked. The store owner prevented him from going in the upstairs area and eventually asked Mr. Knipstrom to leave the premises. Mr. Knipstrom's behaviour continued and he would not leave, so the store manager contacted the RCMP for assistance.

Constable Chad Mufford and Constable Annie Labbe were dispatched and arrived at the store approximately 15 minutes after the initial call. Following an attempt to engage Mr. Knipstrom in conversation to assess the situation, a physical altercation occurred. The members resorted to a variety of hand techniques and intermediary and impact weapons, including oleoresin capsicum (OC) spray, a conducted energy weapon<sup>1</sup> (CEW) and a baton. All attempts and techniques used had little or no effect on Mr. Knipstrom. Eventually, backup arrived and they were able to take Mr. Knipstrom to the floor. It took a number of members to restrain and handcuff him.

First responders and Emergency Health Services (EHS) were dispatched to the scene and Mr. Knipstrom was transported to the Chilliwack Hospital, where he suffered a cardiac arrest shortly after his arrival. Resuscitation efforts by hospital staff were successful, although Mr. Knipstrom never regained consciousness. He was subsequently transferred to the Surrey Memorial Hospital, where he died on November 24, 2007.

### **Chair-Initiated Complaint and Public Interest Investigation**

The Commission for Public Complaints Against the RCMP (Commission) first became engaged in the incident on November 20, 2007, when it deployed an independent observer to the RCMP's criminal investigation into events surrounding the death of Mr. Knipstrom. On the same date, the former chair of the Commission also 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. Knipstrom's behaviour, and the police investigation of the death of Mr. Knipstrom. The Chair-initiated complaint was referred to the RCMP for

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<sup>1</sup> 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.

investigation. Having not yet received a response from the RCMP to the Commission's complaint, on January 30, 2009, the Commission notified the RCMP Commissioner that it considered it advisable in the public interest for the Commission to investigate this complaint pursuant to subsection 45.43(1) of the *Royal Canadian Mounted Police Act* (RCMP Act).

The formal parameters of the Commission's investigation were as follows:

1. Whether the members involved in the events, from the moment of initial contact until Mr. Knipstrom's transfer to the care of emergency health personnel, complied with all appropriate policies, procedures, guidelines and statutory requirements; and
2. Whether the RCMP conducted an adequate investigation of the incident.

### **BCCLA Complaint**

On November 27, 2007, the British Columbia Civil Liberties Association (BCCLA) filed a complaint with the Commission with respect to the treatment of Mr. Knipstrom. On February 18, 2008, the RCMP sent a letter to the BCCLA, indicating that it was terminating the complaint pursuant to paragraphs 45.36(5)(a) and (c) of the RCMP Act. The reason given was to "avoid unnecessary multiplicity of proceedings," citing the criminal investigation and coroner's inquest. On April 11, 2008, the BCCLA requested a review of that decision.

In similar cases, the Commission did not accept the reasoning provided by the RCMP to the BCCLA to justify its decision not to investigate the public complaint. Nonetheless, the subject matter of the Commission's Chair-initiated complaint and subsequent public interest investigation encompassed that of the BCCLA's complaint. In addition, the BCCLA's original complaint stated that it believed that an independent investigation was warranted due to the public interest, rather than a public complaint investigation performed by the RCMP. As such, the Commission treated its Interim Report, and treats this Final Report, as a full response to the BCCLA's complaint and request for review notwithstanding the RCMP's termination of its investigation into the BCCLA complaint.

### **Commission's 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 25, 2009 (**Schedule 1**), in which it made 28 findings and 4 recommendations for change.

Overall, the Commission found that the subject members acted reasonably and that the investigation was conducted appropriately for the most part. However,

the Commission identified several concerns with the investigation that have also been identified in numerous other reports by the Commission and required addressing by the RCMP.

### **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 August 10, 2011, the Commission received the RCMP Commissioner's Notice (**Schedule 2**). The RCMP Commissioner accepted all but two of the Commission's findings and agreed, wholly or in part, with three of four of the Commission's recommendations.

The RCMP Commissioner disagreed with the finding that a staff relations representative (SRR) should not have been allowed to meet alone with Constable Mufford prior to him completing his duty to account statement, or with either Constable Mufford or Constable Labbe prior to the arrival of the investigation team. The RCMP Commissioner also did not support the first recommendation based on that finding, namely to "formalize the attendance 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." However, as noted in the Commissioner's Notice, the RCMP has since put into place the RCMP's Responsibility to Report Policy (in effect since September 7, 2010), which essentially addresses this issue. The RCMP Commissioner supported the second recommendation, which was to clarify "the requirement, timeliness and use of the duty to account that members are obliged to provide" and which is addressed in the 2010 Responsibility to Report Policy.

The RCMP Commissioner also disagreed with the Commission's finding that it was inappropriate for subject members to be interviewed by members of the same or lower rank. In his view, "the necessity to obtain the subject members' accounts of the events at the time outweighed any potential concerns of having a member of the same or lower rank conducting the interview." However, I note that there was no evidence that a member of a higher rank was not available to conduct the interviews, and the record indicates that there were a number of members who attended the scene of this serious incident that were, at a minimum, higher than the constable rank. Even before it was known that Mr. Knipstrom would not survive, the incident was serious enough that steps should have been taken to avoid any real or perceived lack of impartiality from the beginning. In addition, I do not accept the RCMP Commissioner's reliance on the fact that there was no policy in effect at the time requiring that members of higher rank interview subject members; a lack of directly relevant policy on the topic does not in and of itself make conduct appropriate. Nevertheless, I note

that the RCMP has since implemented its External Investigation or Review Policy in an attempt to address these and other issues. The RCMP Commissioner also agreed, in principle, with the Commission's recommendations that all interviews of members involved in serious incidents should be conducted by members of a higher rank in cases where the Major Case Management (MCM) model has not been employed and that all witness interviews in serious incidents should be conducted by a two-member team.

I note that despite the RCMP having put policies in place that generally address the Commission's concerns in February and September 2010, some two and ten months respectively following the Commission's Interim Report, the RCMP took nearly twenty-one months to issue its response to the Commission's Interim Report. In my view, that 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.

### **Commission's Findings and Recommendations**

As a result of the Commission's investigation, it made a number of findings and recommendations that it believed would assist the RCMP in enacting and reviewing policies and in shaping training to ensure that such a tragic situation is not repeated. I reiterate the Commission's findings and recommendations.

**FINDING: Constables Mufford, Labbe and Kardos had current RCMP certified training in the use of force options available to members in the performance of their duties.**

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

**FINDING: It was not unreasonable for the members to use OC spray and a baton in the manner that they did, and it was in compliance with RCMP use of force policy.**

**FINDING: It was reasonable for the members to use the CEW when other use of force options (empty hand techniques, OC spray, baton) appeared to have no effect on Mr. Knipstrom.**

**FINDING: Constable Mufford's deployment of the CEW was reasonable in the circumstances.**

**FINDING: Constable Labbe's decision to deploy her CEW following Constable Mufford's deployment was reasonable in the circumstances.**

**FINDING: Constable Kardos' deployments of the CEW were reasonable in the circumstances.**

**FINDING: It was reasonable for the members to conclude that Mr. Knipstrom was not receiving the full effects of the CEW deployments, if any from some deployments.**

**FINDING: Constable Labbe's decision to recycle her CEW, and to attempt to use a second cartridge when the recycling appeared to have little to no effect, was reasonable in the circumstances.**

**FINDING: Constables Mufford, Labbe and Kardos exercised their use of force options in a manner consistent with the law and RCMP policy.**

**FINDING: To the extent that the subject members were involved in the decision to maintain Mr. Knipstrom in the prone position after his arrest, it was reasonable for them to do so in the circumstances.**

**FINDING: The members appropriately sought and obtained medical treatment for Mr. Knipstrom.**

**FINDING: The RCMP members involved in the events involving Mr. Knipstrom on November 19, 2007, from the moment of initial contact until transfer to the care of emergency health personnel, complied with all appropriate policies, procedures, guidelines and statutory requirements for the arrest and treatment of persons taken into custody.**

**FINDING: The scene was properly secured.**

**FINDING: The appropriate personnel were dispatched to the scene at the appropriate times.**

**FINDING: An "independent" investigation team was assembled in a timely manner, in accordance with RCMP policy.**

**FINDING: The investigation was managed in accordance with the Major Case Management principles.**

**FINDING: All of the relevant witnesses were interviewed.**

**FINDING: The investigators acted reasonably in their efforts to interview and take statements from the involved members.**

**FINDING:** An SRR should not have been allowed to meet alone with Constable Mufford prior to him completing his duty to account statement, or with either Constable Mufford or Constable Labbe prior to the arrival of the investigation team.

**RECOMMENDATION:** If the protocol of SRR attendance is to continue, the RCMP should formalize the attendance 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.

**RECOMMENDATION:** I reiterate my recommendation in the Ian Bush decision (November 2007) and St. Arnaud decision (March 2009) 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.”

**FINDING:** It is inappropriate for subject members to be interviewed by members of the same or lower rank in cases where the MCM model has not been employed.

**RECOMMENDATION:** All interviews of members involved in serious incidents should be conducted by members of a higher rank in cases where the MCM model has not been employed.

**RECOMMENDATION:** All witness interviews in serious incidents should be conducted by a two-member team.

**FINDING:** It was inappropriate for Constable Kardos to be assigned to interview the two main civilian witnesses, as he was involved in the incident and was in a conflict of interest situation.

**FINDING:** The RCMP policy regarding the testing of CEWs that was in place at the time of the incident was inadequate. However, I am satisfied that the change in RCMP policy has clarified when the testing should be done where a CEW has been involved in an in-custody death situation.

**FINDING:** The extent to which the investigators looked into Mr. Knipstrom’s background and used that information was reasonable and appropriate in the circumstances.

**FINDING:** The extent to which the investigators explored the role of excited delirium in the death of Mr. Knipstrom was not unreasonable in the circumstances.

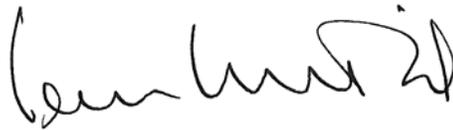
**FINDING:** The RCMP’s communications with the coroner’s office prior to Mr. Knipstrom’s death were not unreasonable or inappropriate in the circumstances.

**FINDING: There was no evidence to support a prosecution and it was reasonable not to submit a Report to Crown Counsel for review.**

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

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

September 9, 2011



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Ian McPhail, Q.C.  
Interim Chair

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