EXECUTIVE SUMMARY

Chair-Initiated Complaint and Public Interest Investigation
In-Custody Death of Mr. Clay Willey
Prince George, British Columbia, July 22, 2003

Introduction

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, leading two members to use their conducted energy weapons[1] (CEW) 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 ongoing public concerns expressed about the level of force used in this incident, the Commission for Public Complaints Against the RCMP (the Commission) exercised its authority on behalf of the public, to examine the facts that gave rise to the public's concerns. The purpose of its report is to provide an objective and thorough assessment of the facts and offer recommendations to prevent a reoccurrence of a similar tragedy. The Commission examined the facts of this case in detail with a view to determining:

1. whether the RCMP officers involved in the arrest and detention of Mr. Willey, from the moment of initial contact until the time of his 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.

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

[1] 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.

4. whether any video evidence, other than the compilation video considered at the Coroner's Inquest, exists and whether any RCMP member concealed, tampered with or otherwise inappropriately modified in any way, any evidence, in particular any video evidence, relating to the arrest of Mr. Willey.

Commission's Review of the Facts

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

Mr. Willey was found behaving aggressively toward a mall security guard. He was confronted by officers, but did not respond to their verbal commands. He was not armed. Mr. Willey was taken to the ground and a violent struggle ensued. It took three officers to subdue Mr. Willey. He apparently demonstrated incredible strength and seemed oblivious to pain control techniques. Officers believed Mr. Willey to be in a drug-induced state. During the arrest, he was pepper-sprayed, punched twice and kicked twice before the handcuffs could be applied. Even in handcuffs, the struggle continued, leaving members with the need to bind his legs. The only device available to them was a hog-tie rope, the use of which had been discontinued by the RCMP. The senior member at the scene made the decision, for safety reasons, to apply the hog-tie. A decision was also made to take Mr. Willey to cells rather than to the hospital at that time.

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

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

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

Key Issues in This Report

1. Police Intervention and Use of Force

It is clear from the Commission's investigation that constables Graham and Fowler were acting in the course of their duty when they started to interact with Mr. Willey. They were investigating a disturbance and found Mr. Willey behaving aggressively, and he would not follow their instructions. They had reasonable grounds to believe that Mr. Willey was causing a disturbance contrary to section 175 of the *Criminal Code* and that he was arrestable. Due to his unpredictable and violent behaviour, it was necessary to restrain him by means of physical force. Constables Graham, Fowler and Rutten had a reasonable fear of physical harm to themselves or others that led them to exercise their use of force options in a manner consistent with the policies of the RCMP and the legal statutes. While Constable Rutten's use of OC spray may have been ill-advised given the risk of cross-contamination, he reasonably believed that it could assist in bringing Mr. Willey under control and, therefore, its use was proportional and reasonable in the circumstances.

Even when the handcuffs were applied to restrain Mr. Willey's wrists, the struggle was not over. Constable Graham reasonably concluded that he needed to secure Mr. Willey's legs. He considered his options and decided to apply a hog-tie. The hog-tie had been discontinued by the RCMP as of May 2002. However, in July 2003 front-line police officers in Prince George had not yet been trained or equipped to use the replacement restraint, and the rope used to apply the hog-tie was still carried in RCMP vehicles. Constable Graham's decision to apply a hog-tie was reasonable, as he had no other available options to secure Mr. Willey's legs and reasonably feared that Mr. Willey would get up and continue fighting.

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.**

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

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

2. Application of Force Following Initial Arrest

Mr. Willey was transported from the scene of the arrest to the Prince George RCMP Detachment cells. Upon arrival, constables Kevin O'Donnell, Glenn Caston, Jana Scott, and John Edinger were present. Mr. Willey continued to strain against his restraints and was generally non-communicative (other than grunting and making other incoherent noises). A number of the members believed Mr. Willey to be on drugs. He was removed from the police vehicle shortly after arrival. Constable Caston and Constable O'Donnell had locked up their firearms in the bay lockers, as per RCMP policy, and proceeded to remove Mr. Willey from the vehicle. Constable Scott stood with her firearm out while Mr. Willey was removed from the police vehicle. Constable Edinger also did not secure his firearm. However, there was neither an urgency to the removal of Mr. Willey from the police vehicle that prevented Constable Edinger from securing his firearm nor any valid explanation provided by Constable Scott and O'Donnell that justified a need for lethal force over watch that would otherwise be prohibited by RCMP policy.

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

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

As to his removal from the vehicle, Mr. Willey was pulled from the police vehicle by his feet. Constables Caston and O'Donnell chose to pull Mr. Willey out feet first, without anyone or anything to break his fall when he came off the end of the back seat. Consequently, Mr. Willey was pulled out and fell, first striking the door

frame and then landing on the concrete floor. In my view, their actions were unreasonable.

No additional care was taken when dragging Mr. Willey face down across the elevated aluminum threshold in the doorway that connected the security bay to the hallway to the elevator. The placement of Mr. Willey into the elevator demonstrated no improvement in his treatment. No attempts were made to facilitate a more controlled transfer, despite there being four members present. The members failed to treat Mr. Willey with the level of decency to be expected when he was removed from the police vehicle and transported to the elevator.

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

b) CEW deployment

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

Constable Caston and Constable O'Donnell appear to have been of the same mind with respect to the use of the CEW in these circumstances, as they are seen on the cell block video simultaneously using their CEWs in push stun mode.[2] There was no evidence to indicate that Mr. Willey was striking out at members; rather, he was straining against his restraints, which would constitute active resistance. RCMP policy at the time specified that the CEW may be used against "suspects who resist arrest." While resistant behaviour may sometimes be classified as "non-compliant," it does not always equate to resisting arrest. The members wanted Mr. Willey to stop straining against his restraints; however, the fact remains that he was restrained. There is a significant difference between using a CEW to gain compliance from a subject in order to apply restraints when they are resisting the physical act of arrest and could potentially escape, and using a CEW to "calm down" a subject once they are already restrained.

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

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

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.

3. Medical Treatment

The RCMP owes a duty of care to those in its custody, and its policies provide direction to members with respect to obtaining medical treatment for prisoners. Mr. Willey had clearly suffered injuries and there was reason to believe that he was either suffering from a drug overdose or had ingested a combination of drugs and alcohol. The duty of care owed by police officers to those in their custody and RCMP policy required that the members obtain medical assistance for Mr. Willey immediately upon his arrest. However, the members' assessment that it was impractical and potentially dangerous for the public to bring Mr. Willey to the local hospital given his conduct was reasonable in the circumstances. It also would not have necessarily been appropriate to wait at the scene of the arrest for medical personnel, as Mr. Willey presented a danger to the public. Having made the decision to bring him to the detachment, the members should have called an ambulance to meet them there to assess Mr. Willey.

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

There were also issues with respect to the level of information that was communicated by those involved with Mr. Willey's arrest to the ambulance attendants. One ambulance attendant indicated that when assessing Mr. Willey's spinal concern, he asked members if Mr. Willey hit his head or anything of that nature. He was told no. However, there were various points throughout the incident where Mr. Willey may have hit his head. The RCMP's failure to communicate this information could have compromised Mr. Willey's medical care. In addition, it does not appear that the ambulance personnel were made aware that Mr. Willey had been pepper-sprayed. That fact should have been communicated so that Mr. Willey could be decontaminated at the earliest possible opportunity.

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

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

4. Timeliness of the investigation

The North District Major Crime Unit (MCU), was enlisted to assemble a team to investigate the possible in-custody death within approximately 20 minutes of Mr. Willey going into cardiac arrest, in accordance with RCMP policy that requires that an "independent" investigation be conducted immediately when someone being arrested or in RCMP custody/care is seriously injured or dies. The investigative team arrived at the scene of the arrest in just over an hour. No members of the investigative team had a substantial connection to the members involved in the incident. The key aspects of the investigation were completed, and expert reports obtained well within six months of the incident. While there were some deficiencies in the investigation itself, as noted elsewhere in this report, it was conducted in a timely manner.

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

5. Securing and Collecting the Evidence

The member assigned to secure the scene of the arrest prior to the arrival of the investigative team was shown the scene but then left it briefly before returning to set up the perimeter and maintain security. As such, the RCMP failed to ensure that the scene was properly secured.

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

The Prince George Forensic Identification Section (FIS) was called to the scene of the arrest and marked, measured, and photographed the area, and swabbed the areas of bloodletting on the pavement. In the days following Mr. Willey's arrest and subsequent death, members of the FIS also obtained and processed the video evidence that was seized from the detachment.

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

Use of force was a key issue in this investigation. As it turned out, Constable Rutten reported that he had kicked Mr. Willey twice. At the coroner's inquest, counsel for the family asked witnesses about marks on the body that could be related to those kicks. Investigators should have collected the footwear worn by Constable Rutten to photograph the tread pattern for potential comparison against the body and Mr. Willey's clothing.

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

The police vehicle used to transport Mr. Willey from the scene of the arrest to the detachment was not examined by investigators prior to it being cleaned.

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

Mr. Willey was initially suspected of having a knife, which was later determined to be a cell phone. The cell phone was collected at the scene. It appears that the phone was inadvertently dropped in the parking lot of the hospital and picked up by someone associated with the Willey family. It should have been apparent to investigators that the cell phone (a potentially important piece of evidence) was missing, but that was never determined.

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

As the events leading up to the arrest of Mr. Willey and the arrest itself occurred in public places, there were a number of civilian witnesses to these events. Statements were taken from the civilian witnesses immediately following the incident or otherwise upon being identified. There was no evidence that the investigators failed to locate or interview any relevant witnesses in a timely manner.

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

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. The primary members involved in this incident were sent home prior to the arrival of the MCMT investigators. The members returned the next evening to meet with counsel and prepare their occurrence reports. It was not until the morning following this meeting—more than 36 hours after the incident—that counsel provided the members' written reports to investigators.

The investigator is at liberty to obtain at least a basic account from an involved member without anyone potentially having first discussed the facts of the situation with the member. That did not occur in this case. At the time of

Mr. Willey's arrest and subsequent death, the RCMP did not have a clear policy explaining to members their obligations in providing an account of events when they are involved with or witness to a serious incident. 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. Current policy reflects and clarifies that requirement.

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

The investigative team did conduct oral interviews with a number of members after their written reports were received. Those members were not compelled to participate in such interviews but did so voluntarily. However, interviews with the two primary members who dealt with Mr. Willey at the detachment took place over five and six minutes. Members were not asked to address the "whys" of their conduct, nor were they questioned about discrepancies between their statements and the detachment video.

The RCMP has since implemented policy that would see the investigations of serious incidents handled by external law enforcement agencies. The Commission is hopeful that investigation by an independent police agency will help to ensure that all aspects of an incident are adequately canvassed by investigators.

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

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

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

6. Independent Officer Review

The circumstances related to the death of Mr. Willey were also reviewed as part of an Independent Officer Review (IOR). An IOR is an internal administrative review. Several issues arose with respect to the IOR process itself and the relationship between the IOR and the MCU investigation. While the reviewer acknowledged that he had concerns about some of the members' conduct, these concerns were not all addressed in his report. He was not aware of who read his report and he did not have any discussions with anyone about it after it was submitted.

The reviewer's role was to conduct an administrative review. He was not to be an investigator. He was to rely on the work of the MCU investigative team. This

process was flawed, as there was clearly a gap between what the MCU saw as its role—to investigate criminal conduct only—and the role of the reviewer in completing the IOR and to measure the conduct of the members against policy and training. However, the investigation itself was not concerned with policy and training issues. Consequently, conduct issues and breaches of policy went unidentified. The RCMP should clarify the roles of each investigative/reviewing party to ensure that both the criminal and conduct aspects of an investigation are adequately addressed. This way, critical opportunities to address shortcomings in behaviour or policy and training will not be missed.

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

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

7. Video Evidence

The Willey family has told the Commission that it believes that, as part of an alleged cover-up, critical information showing how Clay Willey was treated while in police custody has been edited out of the videotapes. Consequently, the Commission retained the services of an independent certified forensic video analyst to verify the integrity of the video evidence in this matter. The video expert determined that the videotapes provided to the Commission were, in fact, the original videotapes and had not been altered in any way. From those videotapes, he was able to create a viewable video presentation of the time Mr. Willey spent in RCMP custody at the Prince George Detachment. The camera angle that should have shown Mr. Willey's removal from the police vehicle displayed a frozen image. The video expert determined that this was a function of the video recording system and was not the result of human intervention.

The video expert did, however, note some discrepancies between the copy created by the RCMP and shown at the coroner's inquest and the original videotape, as well as an initial copy that had been provided to the coroner's office. The discrepancies were in the form of missing frames[3] that were otherwise captured on the original videotapes. The video expert could not determine why frames were missing from the copies—i.e. whether it was the result of user error in the processing of the video, the fault of the equipment used in doing so, or whether the person processing the video chose to exclude certain portions of video. However, the Commission has reviewed all of the video

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

footage in detail and has determined that the additional frames did not materially add to the general presentation of the video record of what happened to Mr. Willey.

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.

There was an issue with the quality of the video recording that was shown at the coroner's inquest. By all accounts, it was difficult to view. Two issues arise from it: With respect to the quality of viewing, the video analyst retained by the Commission was able to assemble a much clearer version using software and technology that was available at the time the incident occurred. There were also portions of footage which were not included in the copy to the coroner. While they did not materially affect the overall picture of what happened while Mr. Willey was at the detachment, the RCMP should make efforts, in the interest of full disclosure, to ensure that all footage is disclosed.

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

Conclusion

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

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