RELEASE DATE: MAY 20, 2021

Manitoba

THE PROVINCIAL COURT OF MANITOBA

IN THE MATTER OF: *The Fatality Inquiries Act* C.C.S.M. c. F52

AND IN THE MATTER OF: WILLIAM SAUNDERS (DOD: NOVEMBER 15, 2017)

Report on Inquest of Judge Lindy Choy
Issued this 17th day of May, 2021

APPEARANCES:

ASHLEIGH C. SMITH, Inquest Counsel
ANDREW J. McKELVEY-GUNSON, Counsel for the family of William Saunders
ERICA A. P. HAUGHEY, Counsel for the Royal Canadian Mounted Police
JIM R. KOCH, Counsel for the Province of Manitoba

RELEASE DATE: MAY 20, 2021

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THE FATALITY INQUIRIES ACT

REPORTED BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: WILLIAM SAUNDERS

Having held an inquest respecting the said death on November 2, 3, 4, 5, and 6, 2020, and March 16, 2021 at the City of Winnipeg, I report as follows:

The name of the deceased is: WILLIAM SAUNDERS

The deceased came to his death on the 15th day of November, 2017 by means of multiple gunshot wounds.

I make no recommendations but do provide comment as set out in my report.

Attached hereto and forming part of my report is a list of exhibits required to be filed by me.

Dated at the City of Winnipeg, in Manitoba, this 17th day of May, 2021.

"original signed by Judge Choy"

Judge Lindy Choy

Copies to:

1. Dr. John Younes, A/Chief Medical Examiner
2. Chief Judge Margaret Wiebe, Provincial Court of Manitoba
3. The Honourable Cameron Friesen, Minister Responsible for *The Fatality Inquiries Act*
4. Dave Wright, Deputy Minister of Justice & Deputy Attorney General of Manitoba
5. Jeremy Akerstream, Assistant Deputy Attorney General
6. Ashleigh C. Smith, Inquest Counsel
7. Andrew J. McKelvey-Gunson, Counsel for the family of William Saunders
8. Erica A. P. Haughey, Counsel for the Royal Canadian Mounted Police
9. Jim R. Koch, Counsel for the Province of Manitoba
10. Exhibit Coordinator, Provincial Court of Manitoba
11. Aimee Fortier, Executive Assistant and Media Relations, Provincial Court of Manitoba

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THE FATALITY INQUIRIES ACT

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RESPECTING THE DEATH OF: WILLIAM SAUNDERS

TABLE OF CONTENTS

I. MANDATE OF INQUEST

[1] On November 14, 2017, 18 year old William (Bill) Saunders was being transported from the Lundar RCMP Detachment to Winnipeg Remand Centre by an RCMP officer. Midway, at the side of Highway 6 between St. Laurent and Woodlands, the lone officer let Mr. Saunders out of the van to relieve himself. Mr. Saunders attacked the officer, and a struggle ensued, during which Mr. Saunders got shot in the shoulder. Eventually Mr. Saunders overcame the officer and drove away in the van. Later that evening, RCMP located the van and started pursuit. The van went off the road, and got stuck in the ditch. The RCMP Emergency Response Team attended, and Mr. Saunders was shot at the scene. Despite resuscitation efforts, Mr. Saunders could not be revived, and he was pronounced deceased.

[2] By letter dated June 1, 2018, the Chief Medical Examiner of the Province of Manitoba directed that an inquest to be held into the death of William Saunders for the following reasons:

> 1. To fulfill the requirement for an inquest, as defined in Section 19(5)(a) of *The Fatality Inquiries Act* (the "Act"):
>
> Presumption of inquest
>
> 19(5) Subject to subsections (6) and (7), an inquest into a death must be held if
>
> (a) The chief medical examiner has reasonable grounds to believe that the deceased person died as the result of the use of force by a peace officer who was acting in the course of duty; or
>
> (b) At the time of death, the deceased person was
>
> (i) in the custody of a peace officer,
>
> (ii) a resident in a custodial facility,
>
> (iii) an involuntary resident in a facility under *The Mental Health Act*,
>
> (iv) a resident in a developmental centre as defined in *The Vulnerable Persons Living with a Mental Disability Act.*
>
> 2. To determine the circumstances relating to Mr. Saunders' death; and

3. To determine what, if anything, can be done to prevent similar deaths from occurring in the future.

II. PARTIES

[3] Ashleigh Smith was appointed Inquest Counsel. Prior to the hearing, standing was granted pursuant to section 28(1) of the *Act* to:

- The family of William Saunders, represented by Andrew McKelvey-Gunson;
- Royal Canadian Mounted Police, represented by Erica Haughey;
- Province of Manitoba represented by Jim Koch.

[4] The inquest took place over six days of hearing in Winnipeg and was completed March 16, 2021. The inquest was unfortunately delayed mid-hearing due to Covid-19 pandemic closures. Thirteen witnesses gave evidence at the inquest. In addition to the ten officers who were directly involved in the incident, Irene Saunders, Mr. Saunders' mother, RCMP Inspector Jared Hall, and Manitoba Chief Sheriff Darcy Blackburn gave evidence at the inquest. A complete list of the witnesses who testified is attached as Appendix "A".

[5] A book of agreed documents was filed, which included a *Hazardous Occurrence Investigation Team Report* ("HOIT"), convened under *The Canada Labour Code* (exhibit 2) and a *Use of Force Review* commissioned by the Manitoba Independent Investigations Unit and Manitoba Prosecutions, authored by Chris Butler, Raptor Protection and Safety Services Inc. (exhibit 3).

[6] This report will first review the circumstances leading up to and surrounding the transport of Mr. Saunders and his escape from custody. It will next examine the steps taken to apprehend Mr. Saunders. Finally, the report will consider recommendations for changes in programs, polices or practices which would serve to reduce the likelihood of deaths in circumstances similar to those that resulted in Mr. Saunders' death.

III. EVENTS OF NOVEMBER 14 AND 15, 2017

A. Escort from Lundar

i. Background

[7] William Saunders (DOB May 29, 1999) was an 18 year old man who resided with his parents and sister in Eriksdale, Manitoba. His family called him Bill. He liked mud bogging, hunting, watching movies and playing video games. He had at one point been employed at a camp with his father, but in November 2017, he was living at home and not working.

[8] Mr. Saunders had some previous involvement with the justice system. He had a youth entry on his criminal record for dangerous operation of a motor vehicle for which he was sentenced to probation.

[9] On October 9, 2017, he was charged with dangerous operation of a motor vehicle, motor vehicle flight, driving while disqualified, and breach of his *Youth Criminal Justice Act* sentence. He was pending on those charges at the time of his arrest on November 12, 2017.

[10] On November 11, 2017, Lundar RCMP received report of a break and enter that occurred at the Boneyard General Repair Shop in the RM of West Interlake. Then just after midnight on November 12, 2017, there was report of a robbery at the Lake Manitoba First Nation Band Hall VLT lounge. The robbery involved the use of a disguise, a firearm and the discharge of bear spray on an employee.

[11] Investigation by RCMP led to the identification of Mr. Saunders as a suspect for both offences.

[12] During the same time period, Mr. Saunders' mother, Irene Saunders, testified that he told her he had been receiving death threats and that she advised him to get help from the RCMP.

[13] On November 12, 2017, at about 2:00 p.m., RCMP attended at the Saunders residence. The family thought that the RCMP were there to help Mr. Saunders. In fact, they were there to arrest him for the break and enter and armed robbery from earlier that day. He was arrested and taken to the Lundar RCMP detachment.

[14] On November 13, 2017, RCMP were opposed to Mr. Saunders' release and he was remanded into custody. His family was advised that he would be taken to Winnipeg the next day.

ii. Court Liaison Unit

[15] The RCMP Court Liaison Unit, or "CLU" is a Manitoba "D" Division unit which operates out of traffic services at the Headingley detachment. The CLU is responsible for movement of prisoners. According to the HOIT, in 2006, an agreement was made between the Manitoba Department of Justice and "D" Division to fund four positions with the mandate to assist the Manitoba Sheriffs with prisoner escorts in the Manitoba East District. The CLU was thus created as an independent unit with the intended purpose to reduce strain on resources for individual detachments. Their priorities in order would be: national transports, court movement and custody transports for East District and assisting with East District detachment remands.

[16] The National RCMP Policy in place at the time of the incident regarding transport of prisoners was filed as inquest exhibit 4B ("2017 Prisoner Escort Policy"). The 2017 Prisoner Escort Policy provided general direction to front line members for the task of prisoner transports in daily duties. It did not contain any specific procedure for rest stops when transporting a prisoner in a motor vehicle.

[17] The CLU, at the time of the incident, had no written policy in place specific to the CLU.

[18] Cst. Terry Davis was the CLU member responsible for the transport of Mr. Saunders from Lundar to Winnipeg. He was a 14 year member of the RCMP who had served at various postings throughout Manitoba. He had been with the CLU since August 2015. Cst. Davis testified that his training consisted of the standard RCMP Academy training in Regina. As for training specific to CLU, the practice was to undergo on the job training by senior officers.

[19] On November 14, 2017, Cst. Davis was scheduled to be on duty from 8:00 a.m. to 4:00 p.m. Earlier that day, Cst. Davis had transported a prisoner from Selkirk to the Winnipeg Remand Centre. He generally worked solo, but in that particular case, the prisoner was large in stature and had mental health issues. Another officer advised that the prisoner had been fixated

on his pistol, so Cst. Davis opted to call for back-up. A second escort officer came, helped get the prisoner into the van, then followed in his vehicle from Selkirk to Winnipeg.

[20] Later that day, Cst. Davis received the request for Mr. Saunders' transport from Lundar. The driving time from Winnipeg to Lundar is approximately one and a half hours. Cst. Davis was aware that the transport would require him to work overtime. It was not uncommon for his duties to take him past 4:00 p.m. and there was frequent opportunity for overtime work.

[21] At the time, when a detachment made a request for transport of a remand, CLU required the following information to be provided:

- Detachment location
- File #
- Prisoner name
- DOB
- Male/female
- Charges
- MHA (Mental Health Act), medications, injuries?
- Any concerns for violence? ie Assault Peace Officer, combative?

[22] The information contained in the request received by Cst. Davis was as follows:

- File number, Mr. Saunders' name and date of birth
- "Robbery 'et al'"
- "No MHA issues or violence issues"
- "No medication"
- "No other concerns"
- "Has been remanded into custody at this point just needs a ride"

[23] In November 2017, the vehicle used by CLU for transporting prisoners was an E150 Ford van. The van was white and unmarked, and equipped with a light bar and sirens. It had a CCTV video system with two cameras focussed on the rear and a monitor in the cab, which was mounted on the ceiling facing back. The van had three cells in the rear, with a centre cell that could fit four people and also two smaller cells.

iii. Pick Up in Lundar and Transport

[24] At about 6:30 p.m., Cst. Davis arrived in Lundar. He was met by another member, then spoke to Mr. Saunders in the holding cell. The standard questions he asked prisoners included whether they had eaten, used the bathroom, had any open sores or wounds, and the state of their mental health. Cst. Davis believes he patted down Mr. Saunders outside the cell and put restraint devices on. Handcuffs were placed in front of the body and 16 inch chain shackles on the ankles.

[25] It was November so there was snow on the ground. Mr. Saunders was allowed to wear his boots and jacket. He was placed in the middle cell and they departed for Winnipeg at approximately 7:18 p.m.

[26] Surveillance cameras in the van recorded the events and the footage was played in court. Mr. Saunders is seen being placed in the van. Approximately 10 minutes later, Mr. Saunders is seen bringing his hands to his mouth. Cst. Davis testified that he noticed Mr. Saunders appeared to be putting something that looked like cardboard to his mouth and asked what he was doing. Mr. Saunders replied that he was chewing his nails.

[27] About 23 minutes later, Cst. Davis stopped the van. What had transpired was that Mr. Saunders told Cst. Davis that he had to go to the bathroom. Cst. Davis wanted to see what Mr. Saunders was fiddling with but also was willing to stop to allow Mr. Saunders to relieve himself. There were no detachments on route. Cst. Davis therefore looked for somewhere on Highway 6 where he could stop safely away from the road.

[28] Cst. Davis was asked about his thought process when Mr. Saunders requested the stop. At the time, there was no policy on how to deal with the situation where a prisoner requests a rest stop. It was up to the officer to make a risk assessment. In his career, Cst. Davis had on other occasions let prisoners out to have cigarettes or go to the bathroom. He said his practice was to

be friendly and respectful. If a prisoner needed something, he would do his best to get it for them. In this case, Cst. Davis assessed Mr. Saunders to be a low risk. His demeanor had been polite. Mr. Saunders asked to have a cigarette before they departed Lundar, and Cst. Davis had allowed him to do so, during which time they stood and had a conversation. There was no indication that Mr. Saunders was going to try to escape. If he felt that there was a higher risk, Cst. Davis testified that he would have asked a second member to assist. Here, he assessed that there was no need.

[29] The video footage shows the passenger sliding door being opened and Mr. Saunders exiting the van. Cst. Davis can be partly seen and he places a jacket inside the van. A short while later he is seen being abruptly pulled by the arm and out of view of the camera.

[30] Cst. Davis testified that when Mr. Saunders was let out of the van, he asked to have the handcuffs removed as they were tight and so that he would not dirty them when he relieved himself. Cst. Davis agreed to remove the handcuffs, thinking that when they were placed back on, he could adjust them. Mr. Saunders then asked to remove his jacket and Cst. Davis agreed, took the jacket, and laid it in the van.

[31] Cst. Davis recalls first being choked from behind. He was able to duck down and flip Mr. Saunders so that they both ended up in the ditch, with Cst. Davis on top. He told Mr. Saunders to stop and tried to strike him, but was not able to regain control. Cst. Davis could not remember the exact order of events, but he recalls struggling and being kicked in the chest, struck in the nose, losing his eyeglasses, and having his left eye gouged. He attempted to use his baton, but it was knocked out of his hand. Mr. Saunders then started to hit Cst. Davis on the head with the baton and struck him 2 to 3 times. At this point, Cst. Davis decided to use his service pistol. He got his pistol in his right hand and tried to force the pistol towards Mr. Saunders' chest. They continued to grapple, with several rounds being shot. The struggling then ceased and Cst. Davis heard Mr. Saunders say: "You fucking shot me." Cst. Davis asked where and he stated: "In the shoulder."

[32] At this point Cst. Davis thought that the fight was over and that he needed to get some help for them both. He was injured and exhausted so at first, he could not get up. He looked around and saw his portable radio on the ground. He went to reach for it when suddenly Mr.

Saunders jumped on him again. Cst. Davis tried to shoot him, but his gun did not fire. It was later found that the pistol had a jammed live round so it could not fire. They then struggled over the firearm and eventually Mr. Saunders wrenched the gun out of Cst. Davis' hand.

[33] Cst. Davis then stood up and thought that Mr. Saunders may try to shoot him. Instead, Mr. Saunders went back to the van, closed the door and drove away to the south.

[34] After the van left, Cst. Davis collapsed at the side of the road. He forced himself to get up and tried to flag down a passing motorist. Several vehicles passed without stopping. He then saw his van drive by, heading north on Highway 6. Cst. Davis remained at the side of the road until finally someone stopped to assist him. At 8:13p.m., he contacted dispatch to advise them of what occurred, then collapsed and was taken to the hospital.

B. Apprehension of William Saunders

i. Background

[35] Nine officers who were involved in the apprehension appeared as witnesses at the inquest. Testimony was heard from the Incident Commander, five members of the Emergency Response Team ("ERT"), the police dog handler and two local general patrol members.

[36] Testimony was also heard from Irene Saunders. She saw her son that evening when he came to the house. He appeared scared and was bleeding from the shoulder. Mr. Saunders told his mother that he had stolen a van, he had to get far away, and he would contact her when he could. He used a chain cutter to cut the shackles on his legs, gathered a few items into a duffel bag and then left.

[37] Meanwhile, RCMP had been tracing Cst. Davis's cell phone which was still in the van. They were able locate the phone in the area of the Saunders residence. At about the same time, Irene Saunders spoke with the local detachment and advised that Mr. Saunders had just left, headed north. RCMP members came to the residence and conducted a search, but Mr. Saunders had already left.

[38] Evidence was heard about two sightings of Mr. Saunders. At about 8:30 pm he was seen at a Petro Canada gas station approximately 5.4 kms northwest from the scene of the incident.

Surveillance video shows him entering the store with a black jacket hung over his left shoulder. He went back to the washroom briefly, then left the store and drove north.

[39] The van was also seen by RCMP Sgt. James Elliott at the Lake Manitoba gas station, which was closed at the time. Unfortunately, due to misinformation regarding the licence plate number, Cst. Elliott believed that this was not the van they were looking for and did not follow up on it. He drove around the area for a short time, then decided to stay in one position to see if anyone went by. It was then that he saw the same white van headed west on PTH#68. This time he called in the licence plate number and discovered that it was in fact the CLU van.

[40] Sgt. Elliot followed the van. The ERT members were at the Saunders residence so they immediately headed for that area. The weather was poor that night with freezing rain and the roads were icy. Mr. Saunders drove the van at speeds of up to 140 kms per hour on the main reserve road, which is gravel. Sgt. Elliott tried backing off in hopes Mr. Saunders would slow down, but he did not. They approached an intersection close to Lake Manitoba where the road curves and PR417 comes to a dead end. At that curve, the van went off the road and into the ditch. Approximately one mile up the road, RCMP had set up a spike belt and red and blue flashing lights could be seen in the distance.

[41] Sgt. Elliott pulled his RCMP vehicle up and held his position, waiting for ERT to arrive. He observed the van in the ditch and gave radio updates to the ERT team. Initially he reported that the van would not get out of the ditch, then later said that he did not think the van could get out of the ditch, but it was trying hard.

[42] While ERT was en route, there was discussion of possible tactics that could be used to stop Mr. Saunders if he were to get the van out of the ditch, including ramming his vehicle. When they arrived on scene, it became apparent that ramming would not be a viable option. The ERT members exited their vehicles and approached in formation with carbine rifles drawn. As they neared the van, the officers split into two groups, with three going to the drivers side of the van, and two splitting off towards the passenger side.

[43] Throughout, Mr. Saunders continued to shift the van between drive and reverse in an attempt to get out of the ditch. On the radio, there was discussion regarding the possibility of

discharging chemical gas into the van to get Mr. Saunders out of the vehicle. Within seconds shots were fired.

[44] It was later determined that 14 rounds were shot. The ERT officers who discharged their rifles, Cst. Fenton and Cst. Flatt, both testified that as the two members split off towards the passenger side, they crossed towards the front of the van. When they were in the direct path in front of the van, Mr. Saunders put the vehicle into drive and began accelerating. Perceiving the members to be in immediate risk of death or grievous bodily harm, both started shooting almost simultaneously. They continued to fire until the van stopped its forward motion.

ii. Use of Force

[45] As noted earlier, an independent Use of Force Review dated November 20, 2018 by Chris Butler of Raptor Protection and Safety Services was filed as exhibit 3 in the inquest ("Butler Report"). In it, the procedure taught to RCMP officers, called the Incident Management Intervention Model ("IMIM"), is described. When faced with critical incidents, RCMP are trained to utilize the IMIM framework to conduct a continuous risk assessment and make appropriate use of the various levels of intervention which may be available to them in response to the behaviour and actions of the subjects involved.

[46] The IMIM is rooted in seven underlying principles:

1. The primary objective of any intervention is public safety.
2. Police officer safety is essential to public safety.
3. The intervention model must always be applied in the context of a careful assessment of risk.
4. Risk assessment must take into account: the likelihood and extent of life loss, injury and damage to property.
5. Risk assessment is a continuous process and risk management must evolve as situations change.
6. The best strategy is the least intervention necessary to manage risk.

7. The best intervention causes the least harm or damage.

[47] Five resistance behaviour classifications are identified, which may be summarized as follows:

1. Cooperative – there is no resistance and the person willingly complies.
2. Passive resistant – occurs when a person does not comply with officer request through verbal defiance with little or no physical response.
3. Active resistant – occurs when the person resists control by the officer by displaying signs of resistance such as pulling or pushing away, running away, open and angry refusal to respond to lawful commands.
4. Assaultive – person attempts or threatens to apply force to anyone.
5. Grievous bodily harm or death – person acts in a way which would lead the police officer to believe that the suspect's actions could result in death or grievous bodily harm to the public or police.

[48] The IMIM provides eight levels of intervention available to be considered and/or deployed by the officer:

1. Officer presence
2. Verbal intervention, including crisis intervention techniques, verbal and non-verbal communication
3. Empty hand control – soft, including restraining techniques, joint locks, pain compliance, strikes and hand cuffing
4. Intermediate devices, including oleoresin capsicum (OC) spray, chemical agents, conducted energy weapon/taser, canine
5. Empty hand control – hard, including blocks, strikes, carotid control
6. Impact weapons, including hand held weapon used for striking or extended impact weapon

7. Lethal force, meaning use of force that could result in the death of a person (firearms)
8. Tactical repositioning – officers can consider tactically repositioning or disengaging at any point in a situation

[49] After the responding member identifies and classifies the subject's behaviour, the IMIM provides the member with a variety of response options in relation to the perceived behaviour of the subject. The member must then take into account the situational factors such as the environment, number of members present, the number of suspects present, weather conditions, subject and officer size, injury or condition of the officer, availability of back up, nature of incident, types of weapons present etc before selecting the appropriate intervention option. The IMIM is neither linear nor scalar. Based on the subject's behaviour and the situational factors in their totality, the member assesses the risk and selects the best option in an attempt to control the situation as quickly as possible with the least harm or damage.

iii. Use of Force by Cst. Davis

[50] With respect to the use of force by Cst. Davis during the rest stop en route from Lundar, the Butler Report concludes that the use of deadly force by Cst. Davis when he discharged his sidearm at Mr. Saunders was consistent with the IMIM and RCMP policy on the use of deadly force in accordance with s.25 of *The Criminal Code of Canada*. I concur with this assessment. Although the purpose of an inquest is not to attribute blame, there must be an examination of how things were done, and whether there was anything that could have been done differently to prevent similar deaths in the future. As it relates to the escalating levels of intervention deployed by Cst. Davis, I conclude that his progression was justified and appropriate, and no recommendations or further commentary arise out of his use of force.

iv. Use of Force by ERT

[51] With respect to the use of force analysis regarding the apprehension of Mr. Saunders at PR417, the Butler Report ultimately concludes that considering the perception the officers held that Mr. Saunders was in possession of a loaded and functional firearm, and the perception that the van was driving forward with two persons directly in its path, the use of lethal force by

discharging police firearms at Mr. Saunders was consistent with IMIM and RCMP policy and consistent with the broader policing context.

[52] The Butler Report notes, however, two issues with the ERT involvement in the incident. First relates to the potential deployment of chemical agents. The Butler Report states that it was clear from the intent of the Incident Commander that use of gas was a tactic to be considered. In this case, the radio communication for deployment of CS gas came too late in the incident as officers had already approached on foot and were in close proximity of the van. There was insufficient time to make ready and deploy gas. The Butler Report suggests that had prior tactical planning included the deployment of gas, that level of intervention could have been attempted.

[53] The second issue identified was the rationale for the left flank of the baseline to wait until they were just in front of the vehicle before splitting off and moving towards the passenger side of the van. In so doing, the officers essentially created a self-generated jeopardy.

[54] There remain questions as to "what if" either of these two issues had been addressed differently. Possibly, use of lethal force on Mr. Saunders would not have been required. Sadly, it will never be known, and we can only speculate after the fact.

[55] It was submitted by counsel for the Saunders family that the ERT acted hastily and forcefully, and I do not disagree with this statement. That being said, the ERT officers' approach to the situation must be considered in the context of their information regarding an escaped remanded prisoner who had already violently attacked another officer, stolen his vehicle and sidearm and left him for dead. It was an extremely volatile and high danger situation. The Butler Report concludes that the use of force by ERT was within RCMP guidelines, and I concur with that assessment.

[56] With respect to the two identified issues, while there may have been another way of approaching the apprehension, we must be cautious not to second guess decisions which were made during a high stress and rapidly unfolding scenario. In hindsight, the technique was not flawless, but this is not a situation where a systemic issue can be identified which would give rise

to the need to make a recommendation. Execution was not perfect, but the facts do not warrant any recommendations relating to how the apprehension unfolded.

[57] In my view, any recommendations or commentary which may arise out of the facts of this inquest relate to the prisoner transport of Mr. Saunders and that will now be addressed.

IV. PRISONER TRANSPORT POLICIES

[58] The originating incident which caused the entire chain of events was the escape of Mr. Saunders from custody. That incident is at the heart of this inquest and will be the focus of this report.

[59] The facts surrounding the transport were detailed earlier in this report. A number of red flags come up with respect to how events unfolded:

- Only basic information was provided to Cst. Davis regarding Mr. Saunders' background and the specifics of the charges against him. This may have led to complacency on the part of Cst. Davis, particularly in circumstances where Mr. Saunders was cooperative and polite. Cst. Davis had erroneously assessed him to be a low risk.

- Cst. Davis had already worked a full shift and was significantly into overtime hours. Fatigue affects the quality of decision-making and execution of duties.

- The search of Mr. Saunders both at the detachment and before he entered the van did not detect the item which he was manipulating and bringing to his mouth. Later review of the surveillance video seems to identify a plastic knife. If this item had been found earlier, it would have better informed Cst. Davis's risk assessment.

- Cst. Davis as the sole escort made an unscheduled stop of the van and did not notify anyone of his location or reason for the stop.

- The handcuffs were removed from Mr. Saunders to permit him to relieve himself. Again, this was related to Cst. Davis's assessment that this was a low risk situation.

- There was no RCMP policy or procedure to give direction on how a rest stop could be safely accommodated.

[60] Following the incident, a Hazardous Occurrence Investigation Team ("HOIT") was convened under the *Canada Labour Code*, consisting of an employer RCMP representative, an employee representative, an occupational safety officer and a technical advisor. The HOIT report identifies two recommendations:

- The transportation of remanded prisoners in the East District is to be handed over to an agency whose specific mandate is the transportation of prisoners as soon as is practicable (ie. Manitoba Sheriffs).

- The immediate implementation of policy specific to the CLU mandating two person minimum escorts. Further policy will establish the following and is recommended that changes will be implemented within two years:

  - Management reviews be completed as soon as is practicable for CLU, Air and Water transport of prisoners.

  - Pre-escort information to include remand warrant, criminal record, special interest police (SIP), flight risk and any other safety concerns.

  - Secondary search of the prisoner on change of custody.

  - Immediate direction to members on removing prisoners from the confined transport vehicle (i.e. do not stop … but for these conditions …).

  - If a stop is required, stops must be pre-determined (i.e. nearest RCMP detachment, other local police stations, designated gas stations …).

  - All intervention tools must be worn.

  - Immediate review to consider limits on hours/distance allowed in a day for CLU, incorporating industry standards.

- All stops must be communicated to the OCC with the location of the stop so that the OCC can perform status checks for officer safety.

- Establishment of Unit Level Quality Assurance annual reviews.

- All new transport vehicles with CCTV will have swivel monitor screens so the second member can view the monitor. All current transport vehicles equipped with non-swivelling CCTV monitors that face the driver will be retrofitted to the swivel monitor.

- All CLU members and supervisors take mandatory fatigue management training.

[61] As outlined earlier, at the time of the incident, there was no specific national RCMP Policy addressing how to conduct rest stops when transporting a prisoner in a motor vehicle, and no Divisional CLU Policy. Much of the training for the CLU position was learned on the job.

V. RECOMMENDATIONS/COMMENTS

[62] The *Act* gives the inquest judge jurisdiction to make recommendations on changes to provincial laws or the programs, polices and practices of the provincial government or of public agencies or institutions. The RCMP are a federal organization but have nevertheless applied for standing in the inquest and voluntarily participated in the proceedings. While any recommendations arising from this report would not be binding, RCMP counsel has indicated that the RCMP will endeavor to address any deficiencies identified.

[63] While I decline to make any formal recommendations, I wish to make comment on three areas:

1. Creation of Policy on Transportation of Prisoners

[64] At the time of the incident, the 2017 Prisoner Escort Policy was silent on how rest stops were to be conducted. Section 3.1 dealing with escort by motor vehicle only addressed the issue of single officer escort, as follows:

1.1.1. The escort may act as both escort and driver for a single prisoner, provided the:

1.1.1.1. Prisoner is not likely to attempt an escape,

1.1.1.2. Prisoner is not known to be violent or suicidal, and

1.1.1.3. Commander approves.

[65] Inspector Jared Hall of the RCMP testified at the inquest. Inspector Hall is the Community Liaison to Manitoba Justice Safety Division and one of his roles is implementation of the requirements of *The Police Act*. He testified that while policy review is an ongoing process, the Saunders incident did precipitate discussion about the Prisoner Escort Policy and on August 12, 2019, amendments were made to the 2017 Prisoner Escort Policy. Notable changes included the following:

- Sec. 1.1 – Requirement for a continuous risk assessment when conducting a prisoner escort.
- Sec 1.2 – in addition to handcuffs, a member should consider using RCMP-approved restraining devices while escorting a prisoner, based on the member's continuous risk assessment.
- Sec.1.6 – when beginning or taking over a prisoner escort, a member should consider a search of the prisoner for public and police safety.
- Sec.1.9 – a member will record the time and mileage at the beginning and end of a prisoner escort, and will inform the operational communications centre of this information.
- Sec.3.1.1 – amendment to require a continuous risk assessment and 3.1.1.1. was amended to read "the prisoner is not known to present an escape risk."

- Sec.3.1.2. was added which provides:

    1.1.2. During a prisoner escort, the escort should not remove the prisoner from the confined area of the motor vehicle unless they believe it is necessary for the safety of the public, police, or the prisoner.

        1.1.2.1. If the decision is made to remove the prisoner, the escort must:

            1.1.2.1.1. Stop to remove the prisoner in a secure environment (e.g. closest detachment), if possible;

            1.1.2.1.2. Advise the OCC of the location of the removal and the reason for it; and

            1.1.2.1.3. Request backup if the member is acting as both escort and driver.

[66] If the new policy requirements had been in place and followed by Cst. Davis, it is unlikely that the escape which ultimately led to Mr. Saunders' death would have occurred. The red flags related to complacency and the failure to properly assess the risk posed by Mr. Saunders would have been avoided. As described in the HOIT report: "Policies and procedures are designed to influence and determine all major decisions and actions and all activities that take place within the boundaries set by them." I believe that if formal policy and procedure had been in place, any complacency which led to the opportunity for Mr. Saunders to successfully escape custody would have been eliminated.

[67] It is very evident that more formal structure was needed in this situation. In my view, had Cst. Davis been required to follow prescribed policy on how transports should be conducted, and particularly, specific procedure on how to safety accommodate the rest stop, Mr. Saunders' death could have been avoided. This has already been recognized by the RCMP and amendments have been incorporated into the Prisoner Escort Policy. As such, no formal recommendation will be made.

2. Consideration of Mandatory Two Person Escorts

[68] There was significant discussion at the inquest on whether two person escorts ought to be mandated. Darcy Blackburn, Chief Sheriff for the Province of Manitoba, gave evidence at the inquest. Ms. Blackburn testified that sheriff policy is that when transporting prisoners by vehicle from one facility to another, either in a community or between two distant communities, there is a ratio of two sheriff officers for up to eight prisoners. Their practice is to always work in teams of two. There is provision in sheriff policy for one person escorts, but she testified that this has never been done in her experience. The cited reason for the practice is the health and safety of the prisoner and staff.

[69] Inspector Hall testified that operationally, it is not always feasible to require two officers for transport. He stated it would cripple the organization's ability to carry out all its duties. He did not acknowledge that two person escorts is necessarily a best practice and maintained that what is required is to conduct a proper risk assessment. There are many different scenarios that can arise in the context of escorting prisoners and to mandate two persons is not always practical or possible.

[70] The HOIT report recommends the immediate implementation of policy specific to CLU mandating two person minimum escorts. I do not go so far as to make that recommendation. In declining to make that recommendation, I note the following:

- Although sheriff practice is to always work in teams of two, the training for an RCMP officer is more extensive than that undergone by the sheriffs, and covers a wider range of skill sets.

- Intervention tools available to sheriff officers consist of a baton and OC spray, whereas RCMP are equipped with a wider range of tools, including a firearm.

- Single RCMP officers already perform prisoner transports in a variety of contexts, including following arrest of a suspect.

- One of the concerns regarding single officer transport relates to medical incapacity on the part of the officer. Historically, however, this has not presented as a significant problem.

[71] In my view, while a two officer escort undoubtedly provides greater safety and security, if policy safeguards are adhered to and a proper risk assessment is conducted, transport of remand prisoners can reasonably be carried out by a single officer. The practice of having two officer escorts may be considered preferable, but does not need to be mandatory.

3. Division of Responsibility for Transport of Remanded Prisoners in East District

[72] Evidence was heard at the inquest regarding the division of responsibility for transportation of remanded prisoners from local detachments to a correctional facility. Since 2006, responsibility for transports in the Manitoba East District has been shared by RCMP and Manitoba Sheriffs, and currently negotiations are ongoing as to the division of these duties between these two agencies. The HOIT report recommends transfer of these duties to Manitoba Sheriffs as soon as practicable, and so it is clear that from the RCMP's point of view, it would be preferable to pass these duties to the sheriffs. Manitoba Sheriffs may well hold a differing view. Notably, evidence from Ms. Blackburn was that the sheriffs do not perform these duties for other law enforcement agencies, including the Winnipeg Police Service, Brandon Police Service and Dakota Ojibway Tribal Police.

[73] As noted earlier, it was the escape from custody which was the originating incident which ultimately led to the death of Mr. Saunders. The allocation of responsibility as between RCMP and Manitoba Sheriffs did not directly contribute to the incident. Accordingly, I make no recommendation or comment with respect to the division of responsibility for transport. It is a matter which is beyond the scope of this inquest.

I respectfully conclude and submit this Report on this 17th day of May 2021, at the City of Winnipeg, in the Province of Manitoba.

"original signed by Judge Choy"

Judge L. Choy

Manitoba

THE FATALITY INQUIRIES ACT
REPORTED BY PROVINCIAL JUDGE ON INQUEST

RESPECTING THE DEATH OF: WILLIAM SAUNDERS

APPENDIX "A" – LIST OF WITNESSES

Constable Terry Davis

Irene Saunders

Superintendent Ryan Scott McMurchy

Sergeant Kevin James Elliott

Constable Nathan Carter

Sergeant Kent Alexander MacInnes

Constable Micah Fenton

Constable Dalyn Flatt

Corporal Geoffrey Corbett

Constable Clark Plaetnick

Constable Tanner Crone

Inspector Jared Hall

Chief Sheriff Darcy Blackburn

Manitoba

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APPENDIX "B" – LIST OF EXHIBITS

Exhibit #1 – Agreed Statement of Facts

Exhibit #2 – Hazardous Occurrences Investigation Team Report (HOIT)

Exhibit #3 – Use of Force Report

Exhibit #4 – RCMP Policy

- 4A – Prisoner Escort – National (amended 2019-08-12)
- 4B – Prisoner Escort – National (amended 2016-03-23)
- 4C – Prisoner Escort – Divisional (amended 2019-05-15)
- 4D – Prisoner Escort – Divisional (amended 2014-11-21)
- 4E – Court Liaison Supplemental
- 4F – Emergency Vehicle Operations (Pursuits) – National
- 4G – Emergency Vehicle Operations (Pursuits) – Divisional
- 4H – Discharge of Firearm – National
- 4I – Discharge of Firearm – Divisional
- 4J – Incident management Intervention Model
- 4K – Tactical Operations Manual (General)
- 4L – Tactical Operations Manual (Operational Requirements)

Exhibit #5 – Manitoba Sheriff's policy (s. 2-4)

Exhibit #6 – Map – RCMP 'D' Division

Exhibit #7 – Map of locations

- 7A – initial incident
- 7B – final incident

Exhibit #8 – Photographs

Exhibit #9 – Officer Notes

9A – Inspector S. McMurchy
9B – Cst. N. Carter
9C – Cst. G. Corbett
9D – Cst. T. Crone
9E – Cst. C. Plaetinck
9F – Sgt. K. McInnis
9G – Sgt. K. Elliott

USB

Exhibit #10 – Prisoner Transport Van Video

Exhibit #10 – Audio Statement – Bernadette St. Goddard

Exhibit #10 – Video – Gas Station Video

Exhibit #10 – Front Video from Police Vehicle 5A42

Exhibit #10 – Radio Communications (23:47 – 00:10 Lundar/Ashern channel)