Ministry of Public Safety and Solicitor General

# VERDICT AT INQUEST

File No.: 2010-0364-0245

An Inquest was held at The Coroners Court, in the municipality of Burnaby

in the Province of British Columbia, on the following dates March 26th – 29th, 2012

before Mr. Vincent Stancato, Presiding Coroner,

into the death of WRIGHT, Jeffrey James (Alvin) 22 ☒ Male ☐ Female
(Last Name, First Name Middle Name) (Age)

and the following findings were made:

Date and Time of Death: August 7th, 2010 at approximately 01:07 hours

Place of Death: Royal Columbian Hospital (Location) New Westminster, BC (Municipality/Province)

Medical Cause of Death

*(1) Immediate Cause of Death:* a) Perforating Gunshot Wound of the Abdomen

DUE TO OR AS A CONSEQUENCE OF

*Antecedent Cause if any:* b)

DUE TO OR AS A CONSEQUENCE OF

*Giving rise to the immediate cause (a) above, stating underlying cause last.* c)

*(2) Other Significant Conditions Contributing to Death:*

Classification of Death: ☐ Accidental ☒ Homicide ☐ Natural ☐ Suicide ☐ Undetermined

The above verdict certified by the Jury on the 29 day of MARCH AD, 2012.

Vincent Stancato
***Presiding Coroner's Printed Name***

[signature]
***Presiding Coroner's Signature***

| WRIGHT | JEFFREY JAMES (ALVIN) |
|---|---|
| SURNAME | GIVEN NAMES |

**PARTIES INVOLVED IN THE INQUEST:**

Presiding Coroner: Mr. Vincent M. Stancato
Inquest Counsel: Mr. Rodrick MacKenzie
Counsel/Participants: Mr. David Kwan, Attorney General of Canada
Mr. Don Sorochan (with Mr. Greg Cavouras), Counsel for Heather Hannon
Mr. David Eby, Counsel for Allan Wright

Court Reporting/Recording Agency: Verbatim Words West Ltd.

The Sheriff took charge of the jury and recorded 9 exhibits as entered. Twenty two witnesses were duly sworn and testified.

**PRESIDING CORONER'S SUMMARY:**

*The following is a brief summary of the circumstances of the death as presented to the jury at the inquest. The summary and my comments respecting the recommendations, if any, are only provided to assist the reader to more fully understand the Verdict and Recommendations of the jury. This summary is not intended to be considered evidence nor is it intended in any way to replace the jury's verdict.*

On August 6th, 2010 Jeffrey James Wright, his spouse, her friend, Mr. Wright's brother and two neighbours were enjoying each other's company at the Legacy Showroom Lounge ("the Legacy") in Cloverdale. They consumed a few alcoholic beverages each over the course of the evening. Mr. Wright's spouse testified that she was too intoxicated to drive their vehicle and wanted the group of them to take a taxi home. Mr. Wright was not happy with this decision and walked away on his own. His spouse testified that she changed her mind deciding to drive home and attempted to pick up Mr. Wright, but he declined the offer. A short while later the two neighbours offered Mr. Wright a ride home and he accepted.

When Mr. Wright arrived home he began arguing with his spouse and demanded she leave the residence. At 23:27 hours Mr. Wright's spouse used her cell phone to call 911 - she made three such calls over the course of 16 minutes. The first call lasted 34 seconds and was cut off before the operator could obtain the address. During the call she requested police attendance and stated that she could not leave the house when encouraged to do so by the call taker. A short while later, she called again and provided her address and informed the call taker that she had been kicked out of the residence. At 23:43 hours she placed a third call. During this call Cst. Ramsay and Cst. Nguyen arrived at the town home complex.

The officers spoke with the spouse who was standing outside. According to Cst. Nguyen, the spouse stated that Mr. Wright had pushed her out of the residence and locked the door. Cst. Nguyen testified that the spouse stated that the relationship was over and that she wanted Mr. Wright out of the house so that she could pack up some belongings and go to her mother's house. A third officer, Cst. Halm, arrived on scene and he entered the residence with Cst. Ramsay. Cst. Halm approached and interviewed Mr. Wright's brother and the spouse's friend who were on the outdoor patio off the main floor.

A short time later Sgt. Davidson arrived at the residence. He testified that he observed Cst. Nguyen speaking with the common law spouse. Sgt. Davidson did not consult with Cst. Nguyen and proceeded to enter the residence. He and Cst. Ramsay decided to attend to the second floor to check on Mr. Wright's well being. Cst. Ramsay testified that she drew her firearm while ascending the stairs. After clearing the other rooms both officers attended to Mr. Wright's bedroom door which was closed. Cst. Ramsay tried to enter but the door appeared to be blocked. Sgt. Davidson tried to gain entry and the door opened easily. Both police officers entered the room. Sgt. Davidson moved to the right towards the closet. Cst. Ramsay moved to the left. The room was described by both police officers as small and full of furniture leaving little space for movement.

As Sgt. Davidson entered the room he looked to his right and could see someone's head through a crack in the partially opened bi-fold closet door. Sgt. Davidson pushed the closet door backward and into Mr. Wright forcing him toward the rear of the closet. Sgt. Davidson indicated that he could see a shiny metallic object through the crack of the closet door. When he re-positioned himself he could see that Mr. Wright was holding a knife and that an axe was on the closet floor nearby. He testified that he demanded Mr. Wright drop the knife. Sgt. Davidson's evidence was that Mr. Wright rose up out of the closet with the knife and came towards him. He testified that when Mr. Wright was within 2 ½ to 3 feet from him, he fired his service pistol into Mr. Wright's chest.

Cst. Halm also attended to the room just prior to the shot being fired and radioed that they were dealing with "a man with a knife". Upon witnessing Mr. Wright having been shot Cst. Halm requested an ambulance "code 3". Mr. Wright was transported to Royal Columbian Hospital by ambulance where he died.

An autopsy was conducted which revealed a single perforating gunshot wound of the abdomen. The pathologist testified that this wound caused significant damage to the right iliac artery and vein resulting in massive internal bleeding. Toxicology testing revealed a blood ethanol level of 0.19%.

*Pursuant to Section 38 of the Coroners Act, the following recommendations are forwarded to the Chief Coroner of the Province of British Columbia for distribution to the appropriate agency:*

**JURY RECOMMENDATIONS:**

To: Peter Hourihan - Deputy Commissioner
Pacific Region & Commanding Officer
Royal Canadian Mounted Police
657 West 37th Avenue
Vancouver, BC V5Z 1K6

1. Police should announce their presence unless deemed unsafe to do so, based on the circumstances. In addition, the member's attire should be marked with large reflective font (POLICE) on the front and rear of vests.

   ***Coroners Comment:*** *The jury heard conflicting testimony that prompted them to question whether or not the two police officers properly identified themselves prior to entering Mr. Wright's bedroom. While Sgt. Davidson testified that he recalled announcing "Police, Police" before entering the bedroom, Cst. Ramsay was unable to recall if she or Sgt. Davidson identified themselves as police officers. Cst. Ramsay also indicated that she could not recall if they called out Mr. Wright's name despite acknowledging that they knew his name at the time.*

2. That the RCMP reviews current practice and training respecting command, control and communication during multi-officer operations with a view to developing a situational based plan.

   ***Coroners Comment:*** *The jury heard testimony from the police officers present at the scene that they had very little communication amongst themselves and at no time was a plan put in place about how they would tactically deal with the circumstances as they unfolded. Based on the evidence provided by the officers it was also apparent that there was a lack of common understanding about who was the officer in charge at the scene.*

3. More RCMP members should be fully trained and certified on alternative means of intermediate weapons to be used while on duty, such as a Taser.

   ***Coroners Comment:*** *Self explanatory.*

4. That the RCMP considers all possibilities of communication with the subject of complaint prior to initiating contact. That would include the information that is to be requested from the caller from the

OCC/call taker. If not sufficient, the member is to continue questioning the complainant as per the "E" Division Operations Manual, section 7.

***Coroners Comment:*** *The RCMP E-Division Operations Manual (Section 2.4) "Violence in Relationships" (VIR) Policy was entered as evidence (exhibit 7) for the jury's consideration. Section 2.4 (7) provides expectation guidelines for the Operational Communications Centre (OCC) Operator. The policy states that VIR calls must be treated as a priority because they are a significant safety concern to the responding member. Among other things, it states that the call taker should determine if weapons are involved or the suspect has access to weapons and if the suspect is intoxicated by drugs or alcohol. The jury listened to the 911 dispatch tapes and reviewed the transcripts which indicated that neither of these items was ascertained by the call taker nor the police in attendance. The jury also heard that there was no attempt to communicate with Mr. Wright in advance of police entry into his bedroom.*

5. That the RCMP review its' practice of allowing officers to provide their "Duty to Account" in written or full recorded report. This is to be reported to an independent investigator. This shall be documented within a minimum of 24 hours and requires a follow up within 72 hours with no exceptions. During this time, a member shall be required to be assessed by a psychologist and put on administrative leave for a minimum of 8-12 hours of counseling, and deemed fit for duty. In addition to this, a duty to account checklist should be completed. (This form to be created).

   ***Coroners Comment:*** *Through testimony the jury may have concluded that there is inconsistent practice within the RCMP as it relates to the provision of a "Duty to Account". Some officers in this case testified that they provided a written "Duty to Account" very soon after the incident while Sgt. Davidson only provided a verbal statement following the incident and did not submit a written account until three months after the incident. The jury also heard that Sgt. Davison's verbal account of events was given to superior RCMP officials and not to an independent investigator. The jury also heard testimony that Sgt. Davidson was deemed fit for active duty very soon after this incident.*

6. RCMP should review their training to ensure it includes compassionate & empathy techniques.

   ***Coroners Comment:*** *The jury heard that Mr. Wright's family members attended to the Langley detachment shortly after the incident. From the testimony the jury may have concluded that RCMP members treated the family in a way that was not commensurate with the level of compassion and empathy that is reasonable under such circumstances.*

7. Where instances require, notification of Next of Kin should be made by either a physician or Coroner.

   ***Coroners Comment:*** *The jury heard testimony that Mr. Wright's father was notified of his son's death by a police officer and not a Coroner or treating physician. The circumstances of his son's death (police involved shooting) were such that notification by the police had a negative effect on the family.*