Ministry of Public Safety and Solicitor General

File Number: 2008-0228-0360

Province of British Columbia

VERDICT AT CORONERS INQUEST

FINDINGS AND RECOMMENDATIONS AS A RESULT OF THE CORONER'S INQUEST PURSUANT TO SECTION 38 OF THE CORONERS ACT, [SBC 2007] C 15, INTO THE DEATH OF

SURNAME	GIVEN NAMES
DUDLEY	LISA CHERYL

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

in the Province of British Columbia, on the following dates: June 11-14, 2018

before: Brynne Redford, Presiding Coroner.

into the death of Dudley (Last Name) Lisa (First Name) Cheryl (Middle Name) 37 (Age) ☐ Male ☒ Female

The following findings were made:

Date and Time of Death: September 22, 2008 (Date) 18:41 (time)

Place of Death: In air ambulance, in a field, near her home (Location) Mission, BC (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Gunshot wounds to the head and neck

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 14th day of June AD, 2018

Brynne Redford
Presiding Coroner's Printed Name

B Redford
Presiding Coroner's Signature

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PARTIES INVOLVED IN THE INQUEST:

Presiding Coroner:	Ms. Brynne Redford
Inquest Counsel:	Mr. John McNamee
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	Mr. David Kwan and Ms. Liliane Bantourakis, counsel for Royal Canadian Mounted Police Ms. Monique Pongracic-Speier, counsel for Ms. Dudley's family

The Sheriff took charge of the jury and recorded 13 exhibits. 12 witnesses were duly sworn and testified.

PRESIDING CORONER'S COMMENTS:

The following is a brief summary of the circumstances of the death as set out in the evidence presented to the jury at the inquest. This is to assist in understanding, but does not replace, the jury verdict and recommendations. This summary is not evidence.

On the evening of September 18, 2008, a resident of a cul-de-sac in a remote area of Mission, British Columbia called Mission Royal Canadian Mounted Police ("RCMP"), while at a neighbour's home, after he heard what he believed to be multiple shots from a firearm. This individual provided information regarding what he had heard and was not contacted again by RCMP, in person or by phone.

Following the phone call regarding possible shots fired, a Mission RCMP officer was dispatched to the area of the call. The officer arrived in the area, drove around the cul-de-sac in his unmarked police car, and reportedly saw nothing of concern. The officer did not get out of his vehicle and did not make contact with the individual who had initially called police with concerns that he had heard gunshots in the area. A second RCMP officer also responded briefly to the call before being dispatched to another incident. The primary officer concluded his report into the incident in the early morning hours of September 19, 2008 and did not assign the file for any additional follow up.

Several days later, on September 22, 2008, a friend of Ms. Lisa Cheryl Dudley went to her residence, located on the cul-de-sac in Mission where suspected gunshots had been heard on September 18, 2018. After receiving no response to his knocks at the front door, he went to the back of the home. Due to the nature of what he observed, which included broken glass and at least one deceased individual, 911 was contacted and emergency responders attended to the residence.

RCMP arrived on scene around 1700 hours and found one adult male clearly deceased (cross-reference BCCS Case #2008-0228-0361). Ms. Dudley was located in the residence, seated in a chair with obvious traumatic injuries, but was still responsive. While it was

difficult for Ms. Dudley to speak as a result of her injuries, she was able to respond to questions and commands. Emergency Health Services provided emergency medical treatment at the scene before she was moved for transport to an air ambulance. After she was moved, Ms. Dudley became unresponsive and throughout her transport to the air ambulance in a nearby field, she was in and out of cardiac arrest. Following her transfer to the air ambulance paramedics, in consultation with an emergency room physician at Royal Columbian Hospital, Ms. Dudley was declared deceased at 1841 hours on September 22, 2008.

A post-mortem examination was completed at Royal Columbian Hospital on September 24, 2008. The pathologist concluded that Ms. Dudley died as a result of gunshot wounds to the head and neck. The pathologist could not determine whether Ms. Dudley's post-injury course might have differed had she received earlier treatment for her injuries.

Toxicological analysis was completed on blood samples obtained after Ms. Dudley's death. No drugs or alcohol were detected in her system.

The RCMP's Integrated Homicide Investigative Team investigated Ms. Dudley's death, concluding that she was the targeted victim of a homicide arising out of a dispute with another individual. Four people were charged in relation to her death, with criminal proceedings coming to a close in February 2017.

The circumstances of the initial response to the call of possible shots fired were reviewed by the RCMP. In October 2009, all members of "E Division" (British Columbia) received a broadcast reminding them of expectations in first response investigations. This included a requirement that investigating officers make personal contact with a complainant in cases where bodily harm, aggravated assault, or events indicating criminal activity that may jeopardize public safety have been reported. A comprehensive First Response Investigations Policy was later implemented nationally, setting out specific policy standards for all first response investigations involving the RCMP.

While the *Police Act* gives the Director of Police Services authority to create binding standards for police forces in British Columbia, it does not currently allow for standards relating specifically to first response investigations.

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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: RCMP Dispatch Services

1. Review procedures and training, to ensure all dispatch employees properly and thoroughly document all details reported by a complainant.

   Presiding Coroner Comment: *The jury heard evidence that the officer dispatched to the call of possible shots fired on September 18, 2008 was not provided with all relevant details reported by the individual who contacted Mission RCMP.*

2. Review with dispatch employees that all calls are recorded, are sensitive in nature, and could be made public through requests under the *Freedom of Information and Protection of Privacy Act* or other processes.

   Presiding Coroner Comment: *The jury noted the importance of ensuring respectful communication between all individuals, including dispatch employees and police officers.*

To: The District of Mission

3. Review bylaws regarding the visibility of residential addresses from the street.

   Presiding Coroner Comment: *The jury heard evidence that some addresses in Ms. Dudley's neighbourhood were difficult to see and suggested that reviewing bylaws regarding the visibility of residential addresses could assist first responders in locating the correct address when called to a scene.*

To: The Royal Canadian Mounted Police

4. If not already in place, explore the implementation of a policy specific to following up with a complainant regarding matters of potential grievous bodily harm (e.g. shooting, stabbing, etc.). If a policy such as this is already in place, explore increased training relating to awareness of this policy.

   Presiding Coroner Comment: *The jury noted the importance of ensuring proper implementation and training on policy related to matters of potential grievous bodily harm, in order to ensure that all avenues of investigation are exhausted in situations where time may be of the essence*

5. Explore implementation of mandatory routine review and training on the First Response Investigations Policy within all levels of the RCMP.

   Presiding Coroner Comment: *The jury indicated that mandatory review and training on this policy would help ensure that all RCMP members are trained on and aware of their duties and responsibilities.*

6. Explore increased exterior lighting for all unmarked police cars operating in rural areas.

   Presiding Coroner Comment: *The jury heard evidence that the police officer dispatched to the call on September 18, 2008 did not have alley lights on his unmarked police vehicle. Increased exterior lighting would help ensure that first responders have adequate lighting for investigative purposes.*

To: BC Emergency Health Services

7. Explore options for a designated air ambulance that is better equipped to allow patient care during transport.

   Presiding Coroner Comment: *The jury heard evidence that it can be difficult to provide life-saving care (such as chest compressions) once an air ambulance is in transit. An air ambulance that allowed for better patient care during transport would potentially enhance paramedics' ability to treat patients while in flight and improve safety for both patients and crew.*

To: The Minister of Public Safety & Solicitor General

8. Review implementation of a First Responder Investigation Policy (including mandatory follow up with a complainant) for complaints of potential grievous bodily harm (e.g. shooting, stabbing, etc.) for all police agencies in the province of BC.

   Presiding Coroner Comment: *The jury heard evidence that the Director of Police Services does not currently have the authority to create standards relating to first response investigations. The jury indicated that a First Responder Investigation Policy could ensure that all police agencies in British Columbia are held to the same standard and level of accountability.*

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9. Explore implementation of mandatory training regarding response to complaints of potential grievous bodily harm (e.g. shooting, stabbing, etc.).

   Presiding Coroner Comment: *The jury heard evidence that the Director of Police Services does not currently have the authority to create standards relating to first response investigations. The jury indicated that standards for mandatory training could help ensure that members of all police agencies in British Columbia are aware of their duties and responsibilities in cases involving potential grievous bodily harm.*