



### 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

**BROOKS**

SURNAME

**HUDSON DARYL WILLIS**

GIVEN NAMES

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

in the Province of British Columbia, on the following dates: March 1-4, 2021

before: Lyn Blenkinsop , Presiding Coroner.

into the death of Brooks (Last Name) Hudson (First Name) Daryl Willis (Middle Name(s)) 20 (Age)  Male  Female

The following findings were made:

Date and Time of Death: 18<sup>th</sup> day of July, 2015 (Date) 0307 (time)

Place of Death: 1815 152<sup>nd</sup> Street (Location) Surrey, B.C. (Municipality/Province)

Medical Cause of Death:

(1) Immediate Cause of Death: a) Multiple Gunshot Wounds

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 4<sup>th</sup> day of March AD, 2021

L. Blenkinsop  
Presiding Coroner's Printed Name

[Signature]  
Presiding Coroner's Signature



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**PARTIES INVOLVED IN THE INQUEST:**

Presiding Coroner:	Lyn Blenkinsop
Inquest Counsel:	John McNamee
Court Reporting/Recording Agency:	Verbatim Words West Ltd.
Participants/Counsel:	David Kwan, and Maia McEachern counsel for Attorney General of Canada representing the interests of the Royal Canadian Mounted Police

The Sheriff took charge of the jury and recorded **15** exhibits. **17** 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.*

This Inquest dealt with the death of Hudson Daryl Willis Brooks, who died in the parking area of the RCMP District 5 Office at 1815-152<sup>nd</sup> Street, Surrey, of multiple gunshot wounds.

Mr. Brooks was described by his mother as someone who loved his family, friends, and animals and by a friend as a very kind person. He was known as a free spirit with a contagious laugh that lit up any room.

The jury heard testimony about the events leading up to Mr. Brook's death and the police response from three civilian witnesses, and five police officers. The jury also viewed video of Mr. Brooks, recorded before he arrived at the RCMP District 5 Office, and video from the parking lot of that building. In addition, the jury heard audio recordings of the 911 call as Mr. Brooks was approaching the parking lot, and transmissions from police radios.

On July 17, 2015, at approximately 11:30 PM Mr. Brooks was at a gathering of friends. Another friend arrived, saw that Mr. Brooks was there, and shared some magic mushrooms with him. The friend noted that the mushrooms, which he had also used, were unusually potent and they appeared to have a significant impact on Mr. Brooks, who had also been drinking alcohol. Following a possible disagreement with the other friends, Mr. Brooks suddenly left the residence without his belongings. After he left, Mr. Brooks location and activities were unknown until just before the 911 call at 2:39 AM on July 18, 2015.

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A witness saw a young male, in Surrey, wearing shorts and no shoes, walking down the centre of 18<sup>th</sup> Avenue towards 152 Street, yelling and screaming. She was concerned for his safety and made the 911 call. Another person also saw a male of similar description walking down 18<sup>th</sup> Avenue, yelling.

None of the witnesses or RCMP officers knew the identity of the male, who was later identified as Mr. Brooks.

An RCMP Officer, Officer 1, testified that he heard a tone alert. According to the RCMP witnesses, that signaled a high-risk situation. Officer 1 then heard a radio call for a suicidal male at 154<sup>th</sup> Street and 18<sup>th</sup> Avenue, which was two blocks away from the District 5 office at 152<sup>nd</sup> Street and 18<sup>th</sup> Avenue. While pulling out of the parking lot in his marked police vehicle, he looked to the right and saw a young male approaching. He used his radio to advise that he had found the young male, at which point Mr. Brooks started sprinting towards Officer 1's vehicle and Officer 1 locked the doors.

Mr. Brooks, who was still yelling, grabbed the door handle of Officer 1's vehicle with enough force to shake it. Mr. Brooks banged the vehicle and the window with his hands and head while continuing to yell.

Officer 1 believed that Mr. Brooks was trying to get into the vehicle, so radioed for help and activated the emergency lights and air horn. The air horn button became stuck in the on position and the officer was unable to turn it off.

A taxi driver who was passing the entrance to the parking lot saw a male in front of the police vehicle, banging on the hood and then on the driver's side window. He heard the male yelling and screaming. He also heard the air horn and saw that the emergency lights on the police vehicle were activated. He was frightened that the male might turn his attention to his taxi, so he then drove off.

Officer 2 was inside the RCMP District 5 office and also heard the tone alert indicating a serious incident in progress that she understood was taking place several blocks away. Over her radio she heard Officer 1 calling for help. She made her way to the back door of the office and saw the reflected emergency lights through the window and could hear the air horn.

She left and ran towards the lights and air horn, running past her partner, Officer 3, who was seated in the passenger seat of their police cruiser, parked directly to Officer 2's left. Officer 3 joined Officer 2 on her right-hand side, and they ran around the corner directly in front of them, and towards the lights and air horn. Both officers could see Mr. Brooks at the driver's side of Officer 1's vehicle.

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Officer 2 shouted at Mr. Brooks to stop and drew her firearm, planning to distract him away from the vehicle. Mr. Brooks became aware of Officer 2 and charged at her. She backed up to try to get out of his way and as he was rapidly closing the distance between them, she opened fire. As Mr. Brooks didn't stop, Officer 2 fired several more times while running away from Mr. Brooks backwards before falling backwards over a low concrete wall. Mr. Brooks continued to follow her and got on top of Officer 2 who fired several more times. At some point, Officer 2 suffered a gunshot wound to her leg, from her own weapon.

Officer 1 left his vehicle, approached Mr. Brooks, and used Oleoresin Capsicum spray (pepper spray) to help get Mr. Brooks off Officer 1. Officer 1 and 3 were able to pull Officer 2 out from under Mr. Brooks and then Officer 4, who had just arrived, handcuffed Mr. Brooks.

Officer 5 arrived on scene and started first-aid on Officer 2's leg wound. Firefighters from the adjacent Fire Hall also provided first aid to Officer 2 and an ambulance arrived to take over her care. One of the firefighters assessed Mr. Brooks and determined that he was not breathing. After a paramedic took over the care of Officer 2, Officer 5, who had previously been a paramedic, went to Mr. Brooks and confirmed that he had no pulses or respirations and was not moving any air. His pupils were fixed and dilated, which he noted as a sign that Mr. Brooks was deceased.

Additional paramedics arrived and one went to Mr. Brooks and confirmed the findings of another paramedic examining Mr. Brooks that there were no heart sounds, no carotid pulse, and no vital signs. He contacted an Emergency Room Physician at Royal Columbian Hospital and death was confirmed at 3:07 AM. No resuscitative efforts were initiated on Mr. Brooks.

A toxicologist testified that Mr. Brooks had blood alcohol levels showing moderate intoxication, recreational levels of cocaine and its metabolite benzoylecgonine, as well as the presence of cocaethylene and levamisole. He explained that cocaethylene was a toxic product formed after the use of cocaine and alcohol that would prolong the effects of cocaine intoxication. He said that levamisole, a product used to treat parasites in animals, was a filler often added to cocaine that could have somewhat similar effects.

While psilocin (the active ingredient resulting from consumption of magic mushrooms) was not detected in the original report, his further review determined that the testing could neither confirm nor deny psilocin's presence.

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The toxicologist advised that psilocin's impact peaked at approximately two hours after consumption and lasted three to four hours after that peak. There was limited research available as to the effects and duration of magic mushroom consumption since they vary greatly in potency. The combination of alcohol, cocaine and mushrooms would increase serotonin levels and likely increase their effect. He also advised that the levels of cocaine and its metabolite would have been consistent with recreational use and although possible, would rarely cause psychosis.

A forensic pathologist testified that the cause of death was multiple gunshot wounds, and that Mr. Brooks had nine entrance wounds, three of which were inflicted at close range or in contact with Mr. Brooks. Although several of the injuries were serious and a number were minor, the close contact gunshot wound to Mr. Brooks chest damaged his pericardium, ventricle, diaphragm, liver, and aorta causing severe internal blood loss. In combination with the wounds to his abdomen and pelvis these injuries were responsible for Mr. Brooks death. The pathologist found yellowish fragments in Mr. Brooks stomach which could be consistent with mushrooms.

The jury heard from the Chief Civilian Director of the Independent Investigations Office of British Columbia (IIO), that his agency operates independently from the provincial government and the police and investigates police actions which have resulted in serious harm or death. An IIO investigator then outlined their actions investigating Mr. Brooks death. He confirmed that they had been unable to account for Mr. Brooks activities after he left his friend's gathering prior to the witnesses seeing him on 18<sup>th</sup> Avenue, but that his tank top had been located across the park from his friend's residence, and that his fingerprints were found on a damaged vehicle along 18<sup>th</sup> Avenue. They had not been able to determine when or where Mr. Brooks obtained and used cocaine.

A Use of Force Expert testified about the Incident Management Intervention Model that all police officers are trained on. He also discussed the distances that a running individual could cover in a period of time and differences in officer reaction times in those situations that impacts the effectiveness of guns and intermediate weapons, such as Conducted Energy Weapons (Tasers). He noted that the rules around the use of Conducted Energy Weapons had not changed in fourteen years and suggested review and consideration of research that has occurred in the interim. He also advised that receiving file materials from the IIO assists him to develop training for his police department but believes that having this information routinely forwarded would be of assistance.



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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: Royal Canadian Mounted Police, E Division**

1. Increase training frequency of the Incident Management Intervention Model (IMIM), for the RCMP specifically focused on communications in regard to tactical considerations when it comes to use of force.

**Presiding Coroner Comment:** *The Use of Force training Expert testified that communication, regarding strategy and a coordinated plan, would assist in an incident response.*

#### **To: Independent Investigations Office of British Columbia**

2. The Independent Investigations Office (IIO), upon completion of their investigations, provide investigative materials and findings to the RCMP or other affected agency for the purpose of developing training solutions.

**Presiding Coroner Comment:** *The Use of Force Training Expert testified that proactively sharing the Independent Investigations Office investigative material between agencies could help develop valuable and specific training solutions.*

#### **To: Ministry of Public Safety & Solicitor General, Police Services Division**

3. Review current standards of use, training, and consider new technology for Intermediate Force Options including Conducted Energy Weapons.

**Presiding Coroner Comment:** *Evidence was heard that a review of Conductive Energy Weapons (CEW) has not taken place for more than fourteen years and more recent statistical data may be available to help determine success and failure rates, training and retraining of officers and the limitation of requiring lethal overwatch for CEW's, unlike for other intermediate weapons.*