**IN THE MATTER OF A CALGARY POLICE SERVICE FATAL OFFICER-INVOLVED SHOOTING ON DECEMBER 25, 2018**

# DECISION OF THE EXECUTIVE DIRECTOR OF THE ALBERTA SERIOUS INCIDENT RESPONSE TEAM

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| **Executive Director:** | **Michael Ewenson** |
| **ASIRT File Number:** | **2018-69(S)** |
| **Date of Release:** | **November 25, 2022** |

## Introduction

On December 25, 2018, pursuant to section 46.1 of the *Police Act*, ASIRT was directed to investigate the death of a 30-year-old woman as a result of an officer-involved shooting that occurred that day.

## ASIRT's Investigation

ASIRT's investigation was comprehensive and thorough, conducted using current investigative protocols, and in accordance with the principles of major case management. All relevant police and civilian witnesses were interviewed. Calgary Police Service (CPS) video from the HAWCS police helicopter was secured and analyzed, along with all relevant dispatch data and audio recordings. The scene was examined. Finally, the CPS policies relevant to pursuits and vehicle techniques were reviewed. The subject officer, as is his right, declined to provide ASIRT investigators with a statement.

## Circumstances Surrounding the Incident

### *The 30-Year-Old Woman*

The woman involved in this case was 30 years old at the time of her death. She had a young child and a loving family. During the period leading up to December 25, 2018, it appears that the woman had escalating mental health and substance use problems. She had no criminal record and no involvement with police prior to December 2018. However, she had been arrested for possession of a controlled substance on December 18. On December 24, she had been in hospital and had been prescribed a benzodiazepine medication. After her death, police found the medication and two small bags of a suspected controlled substance in her vehicle.

### *Events Preceding the Shooting*

The interactions between CPS and the woman started just before midnight on December 24, 2018, and lasted approximately three hours.

At 11:57 p.m. on December 24, two CPS officers noticed the vehicle registered to the woman being operated on westbound Blackfoot Trail SE from Deerfoot Trail SE. She was

the driver. It was travelling very slowly, but also erratically, including merging, signaling, and changing lanes improperly. Even when the marked police vehicle was beside the vehicle, the woman appeared to be oblivious to its presence. Believing that the driver may be impaired, the officers activated their emergency equipment and attempted to stop the vehicle. The vehicle did not stop, and accelerated away from them. The CPS officers discussed pursuing the vehicle with their supervisor and, due to the risks of a pursuit, did not follow her further at this time.

Shortly after at 12:03 a.m., two other CPS officers noticed the same vehicle on 9 Avenue SE at 13 Street SE. Being aware of the previous interaction with police, they also activated their emergency equipment and tried to stop the vehicle. Again, the woman did not stop. They followed the vehicle from a distance while the police helicopter, HAWC1, came to the location. The two officers noted similar slow but bad driving, including failing to stop at several red lights.

HAWC1 started to follow the vehicle from the air at 12:16 a.m. The vehicle continued to drive slowly and safely, and appeared to the officer in HAWC1 to be trying to figure out where to go. Traffic was light. At 12:39 a.m., HAWC1 stopped following the vehicle when it was required for another call.

At 2:19 a.m., a 911 call was received about the same vehicle, which was now southbound on Falconridge Boulevard NE from 64 Avenue NE. The callers thought that the driver was drunk due to her erratic driving, which included driving through a red light and driving in the wrong lanes. The driver stared at the callers when stopped beside them, and "didn't look like she was all kind of there." Police located the vehicle four minutes later at the intersection of Saddletowne Circle NE and Falconridge Boulevard NE. The vehicle then ran a red light and travelled on the wrong side of the road. More police vehicles entered the area and began to follow the vehicle. The vehicle continued to drive very slowly but poorly.

At 2:35 a.m., HAWC1 began to follow the vehicle again, along with numerous patrol officers in their vehicles. The vehicle was now southbound on Stoney Trail NE approaching McKnight Boulevard NE, travelling at 50-60 km/h in this 100 km/h zone. Traffic was light. The acting staff sergeant in command of the call asked if any involved officers were trained in vehicular intervention techniques at 2:40 a.m. and, when a sergeant said that he was, the acting staff sergeant authorized use of a low speed box-in maneuver to stop the vehicle at 2:41 a.m. The low speed box-in maneuver involved police cars surrounding the vehicle and forcing it to stop by physically restricting its movement.

As the vehicle moved on to McKnight Boulevard NE at 2:41 a.m., CPS officers initiated the low speed box-in maneuver. The sergeant's marked police vehicle was in front of the woman's vehicle. Two other CPS officers were in a marked police vehicle on the driver's side, and two more were behind in a marked police vehicle. They surrounded the woman's vehicle and successfully brought it to a halt. A fourth marked police vehicle with two officers in it then boxed the vehicle in on the passenger's side. Other police vehicles followed, including one that was holding back any traffic that might approach.

The police vehicles at the front, rear, and passenger's side all contacted the woman's vehicle to prevent it from moving. The police vehicle on the driver's side left a gap, which provided an opportunity for the woman to move her vehicle.

Once the woman stopped, multiple officers exited their vehicles. Three of them approached the woman's vehicle. The first was the subject officer. The subject officer was the passenger of the police vehicle on the driver's side, and therefore closest to the woman. While exiting the police vehicle on the driver's side, he told the woman to turn off the vehicle and immediately smashed the driver's side window with his baton. He then began to try to remove her physically from the vehicle.

The second officer to approach the woman's vehicle came from the police vehicle at the rear. He came up on the passenger's side while the subject officer was engaged on the other side, and opened the front passenger's door.

The third officer was the driver of the police vehicle on the driver's side of the woman's vehicle. This officer crawled across the seat and exited on the passenger side. When she exited, she was next to the subject officer, and still within the open door of the police vehicle.

While the officers were exiting their vehicles, the officer in HAWC1 told everyone to stay in their vehicles and watch out for pinch points between the woman's vehicle and the police vehicles. During the short time from the stop to the officer-involved shooting, the officer in HAWC1 warned the other officers three times about the risk of pinch points.

The woman then attempted to free her vehicle from the box by pressing on the gas pedal. When she did so, her vehicle shifted to the left and moved into the gap on the driver's side. It was then no longer fully behind the lead police vehicle, and was able to move a short distance forward before becoming trapped again, now between the lead police vehicle and the one on the driver's side. Only those two police vehicles now contacted the woman's vehicle at all, and the points of contact between the woman's vehicle and these police vehicles changed.

On the passenger's side of the woman's vehicle, the changed contact caused that door to be pushed closed. The officer on that side was at risk of being trapped in this door, but he was able to move to safety.

On the driver's side, the passenger's door of that police vehicle was now being pushed closed by the woman's vehicle. The second officer who had exited this police vehicle was still within the open door, and was not able to get out of the pinch point. Her torso was pinned between the police vehicle's door and body. Due to the force, she was lifted off her feet while trapped. She was unable to remove herself from the pinch.

The woman continued to accelerate her vehicle very aggressively, creating smoke and causing pieces of rubber to fly off the tires. Because the woman's vehicle was now only contacted by two police vehicles on the sides, it was now less confined and more able to move.

The subject officer had remained on the same side of the woman's vehicle as the trapped officer, and was immediately next to her. He was closest to the trapped officer, and to the woman. The woman continued to press down the accelerator on her vehicle aggressively, which made it possible that her vehicle could move within the box, and further press against the trapped officer.

At 2:42 a.m., the subject officer drew his service weapon and fired at the woman three times from close range. All three shots hit her in the head. She was killed immediately. The entire time from the woman's vehicle stopping to the three shots being fired was approximately 40 seconds.

Shortly after the subject officer fired, the box was re-established. The police vehicle in the rear position moved in to contact the woman's vehicle, and another police vehicle moved to the front and successfully blocked the vehicle again. The woman's foot remained on the accelerator. An officer smashed the passenger window and was able to stop the vehicle. Through moving some of the vehicles, the trapped officer was freed. She did not have any injuries.

An autopsy was conducted on the woman. The cause of death was multiple gunshot wounds of the head. Toxicology showed that the woman had cocaine and the prescribed benzodiazepine medication in her system.

The woman's vehicle was inspected for any mechanical faults, including whether it could have accelerated unintentionally. No faults were found.

*CPS Policy*

CPS had policy on the use of the box-in maneuver and other vehicle intervention techniques at the time. This policy stated that the maneuver could only be used in an exigent circumstance, which was defined as a "spontaneous situation where public safety is such that if overt action is not taken, there is a reasonable likelihood of death or grievous bodily harm." This policy further stated that only officers who had been trained or certified in the techniques could utilize them. Of the officers directly involved in the low speed box-in maneuver on December 25, only one, the sergeant, was trained in the technique due to his recent time in the tactical unit. During this time, vehicular intervention training was not offered to patrol officers, so only tactical unit officers were trained in the technique.

**Analysis**

*Criminal Liability of the Subject Officer*

ASIRT's investigation was focused on the question of whether the subject officer's conduct caused or contributed to the death of the woman, and if so, whether that conduct was lawful. As with all officer-involved shootings, it is clear that the actions caused the woman's death. The question remained whether the officer was acting in the lawful execution of his authority and whether the force used was lawful. While not the direct focus of our investigation, the earlier events provided some context to the circumstances leading into the officer-involved shooting.

The woman was experiencing mental health issues during at least December 24 and 25. She had been in the hospital in the early morning of December 24, and was prescribed a benzodiazepine medication. She unfortunately combined this with a controlled substance. The exact nature of and interaction between her mental health issues, prescription drug consumption, and controlled substance consumption are unclear, but it is clear that they put her into a state of confusion and anxiety. This was demonstrated in her driving pattern, which was both odd and dangerous. While mental health and substance abuse issues may reduce the moral blameworthiness of the person suffering from them, they do not erase the risk presented to the public.

While the woman was generally driving very slowly, her driving was still dangerous. A slower speed may make accidents less likely in an ordinary driving pattern, but that is not necessarily true when the vehicle is driving through red lights and on the wrong side

of the road. This type of driving will always present a risk to other users of the road, pedestrians, and the driver herself.

The poor driving by the woman was observed at points over almost three hours. The quality of the driving also appeared to be worse when she was observed later. Shortly after 2:19 a.m., it involved running red lights and driving on the wrong side of the road. She had also failed to stop for police twice already. The risk to the public was increasing over time. However, some of the worst of her driving may have been in response to attempted traffic stops by police, since it occurred immediately after such attempts.

Given her driving pattern, it was reasonable to suspect that she may have been intoxicated. All officers who interacted with the vehicle that night thought she might be impaired. Police are legally permitted to conduct a traffic stop to check the sobriety of a driver in such circumstances. Police were also permitted to stop her in relation to the various offences she was committing under the *Traffic Safety Act*. While failing to stop for police in any situation is serious, failing to stop for them when they are entering into an investigation for a criminal offence such as impaired driving is more serious and therefore requires greater attention from police.

While police officers are lawfully entitled to pursue fleeing suspects, criminal flights are inherently a dangerous situation for all involved – police, the fleeing suspect, and other civilians. Police must recognize that their actions or mere presence may result in dangerous driving from the suspect and higher risk for the public. Accordingly, the decision to pursue a fleeing vehicle must be made carefully, and with constant assessment and re-assessment of the danger involved. In their first interactions with the woman, police did not pursue after such an assessment.

Police vehicular intervention techniques present similar concerns. The technique used here, the low speed box-in maneuver, necessarily involves serious risks. Since the suspect vehicle has already shown it will not stop for police, it must be assumed that some attempt to escape will be made. There will therefore be a high risk of collision between the suspect vehicle and police vehicles while they attempt to put the box in place. If the vehicle is successfully stopped, the risk does not end. The vehicle may still attempt to escape the box. With the close quarters involved around the vehicle, the risk to anyone outside of his or her vehicle is high.

How this played out in the early morning of December 25 demonstrated the risks inherent in the use of this vehicular technique. Only one of the officers involved was trained in the technique. While the box-in maneuver initially appeared to be succeeding

and the woman's vehicle was brought to a stop, any success quickly disappeared. The police vehicle on the driver's side was not close enough to the woman's vehicle and gave it space to move. Numerous police officers immediately exited their vehicles and went to the points where they were at greatest risk of being trapped and crushed if the vehicle moved. The vehicle did move, and one officer was trapped.

The trapped officer was in serious and immediate danger. The woman was heavily applying the gas in her vehicle, to the point that rubber was flying off the tires. The woman clearly had no regard for the obvious danger created by pressing down on the gas while officers were next to her vehicle. It was very possible that the vehicle could move inside the box again. At the point that the subject officer fired, the box was not correctly placed such that she could not move. Given that the officer was already trapped between the door and the frame to the point that she was lifted off the ground, any additional compression could have seriously injured or killed her. Even if the box could be quickly re-established, that would not guarantee no movement from a vehicle applying such force.

Both the trapped officer and the subject officer made tactical errors in the execution of the box-in maneuver that left them vulnerable. It was their vehicle, driven by the trapped officer, which permitted movement by the woman's vehicle. The trapped officer did not stay in the driver's seat and continue to press the brake in order to prevent movement. Mostly importantly, both exited the vehicle and went into dangerous pinch points. It was the presence of officers in the pinch points that lead to the officer being trapped, and it was the officer being trapped that lead to the immediate risk of death or grievous bodily harm to which the subject officer responded. The fact that tactical errors were made does not, however, establish any criminal liability on its own. While the presence of the officers in the pinch points is required for this situation to unfold, the woman holding her foot down on the gas pedal is ultimately responsible. The officers involved had to react to the situation before them.

Under s. 25 of the *Criminal Code*, police officers are permitted to use as much force as is necessary for execution of their duties. Where this force is intended or is likely to cause death or grievous bodily harm, the officer must believe on reasonable grounds that the force is necessary for the self-preservation of the officer or preservation of anyone under that officer's protection. A police officer also has the same protections for defence of person under s. 34 of the *Criminal Code* as any other person.

In this case, the situation became dire quickly. Once the officer was trapped, the risk of serious injury or death was immediate. The longer that the woman's foot was on the gas

pedal in her vehicle, the greater the risk to the trapped officer. A police officer's use of force, in law, is not to be assessed on a standard of perfection nor using the benefit of hindsight and the opportunity to consider alternatives with the luxury of time, recognizing the exigencies of the circumstances and the decisions and reactions that must occur in split seconds. Any option that extended the time that the subject officer took to respond to the risk increased that same risk. In those circumstances, the subject officer's use of lethal force was protected not only by the application of s. 25 of the *Criminal Code*, but s. 34 in defence of another person.

After the subject officer shot the woman, her foot remained on the gas pedal. The shooting, therefore, did not remove the risk to the trapped officer. She remained at the same risk of serious injury or death as she did prior to the shots. This does not mean that the actions of the subject officer were pointless, however. To review his actions using the outcomes, which he could not know at the time, is unreasonable. Based on the information available to the subject officer at the time just before the shooting, it was reasonable to believe that those shots would end the risk to the trapped officer.

*Policy Considerations*

Whether officers follow police policy in the execution of their duties can impact their criminal liability. In this situation, however, the issues related to policy and the use of this vehicle technique do not apply to the subject officer. The subject officer had not been trained in the box-in maneuver used, and his participation in the box-in maneuver was at the direction of superior officers. There is therefore no connection to any criminal liability on his behalf.

While the criminal liability of the subject officer may not be affected by any policy breaches, policy breaches did have an impact on how the incident unfolded. It was known to all officers involved in the call that neither the subject officer nor the trapped officer had the proper training in the box-in maneuver, since it had been discussed immediately prior to the use of the technique that only the sergeant was trained. At that time, only tactical members could be trained in the technique. It is not the fault of the subject officer or the trapped officer that they did not follow training that they did not and could not have. They followed the direction of their superior officers. The sergeant and the acting staff sergeant failed to follow policy that required everyone involved in the technique to have been properly trained in it. The sergeant had been trained in vehicle techniques and knew or should have known this policy. The acting staff sergeant was the highest-ranking

officer involved and also knew or should have known the policy. By continuing with techniques contrary to policy, the superior officers increased the risk to everyone involved. This risk was tragically realized. Using high-risk techniques with untrained officers directly led to the trapped officer being put in a situation of the immediate risk of death or grievous bodily harm, and this directly led to the reasonable use of lethal force by the subject officer.

It is unclear if the vehicle technique used was permitted under CPS policy. The policy requires an exigent circumstance, which is a "spontaneous situation where public safety is such that if overt action is not taken, there is a reasonable likelihood of death or grievous bodily harm." The policy provides a framework for deciding if one of the techniques should be used. This involves balancing the risk presented by the vehicle with the risk created by the technique. It is clear that the woman's vehicle presented a risk to the other users of the road through her driving. As noted above, while she was driving slowly, she was also running red lights and committing various other traffic infractions. A significant amount of the more serious driving appeared to be in response to attempted traffic stops by police. During the time of the woman's driving as observed by CPS, there was little traffic, but not zero traffic. Other users of the road are near her, including the people who called 911 about her driving. The woman did present a risk to these other users of the road, but the policy required "a reasonable likelihood of death or grievous bodily harm" in order to permit vehicular intervention techniques. The officers involved in the early interactions with the vehicle recognized the lower risk involved and ended their potential pursuits immediately. In the later interactions, the woman's driving was worse, but not significantly worse. It is difficult to see how the situation here was spontaneous, as required by policy. Had CPS policy been followed, it is likely that other options for dealing with the woman's vehicle would have been used.

**Conclusion**

The subject officer's conduct should be judged through the lenses of his training and the situation in which he was placed. Based on that and the whole of the evidence, notwithstanding the heartbreaking outcome, there are no reasonable grounds to believe that the subject officer committed any offence. The subject officer reacted to the immediate risk of serious injury or death to his fellow officer presented by the woman.

While she was likely in some state of distress, that does not change the situation on the ground in that moment nor the risk she presented to the trapped officer.

There were serious breaches of CPS policy that led to that dire situation. However, the blame for those breaches does not rest with the subject officer, who was following the directions of his superiors and not trained in the technique used, and they do not give rise to any criminal liability for him. The issue of policy breaches is ultimately one for CPS to address.

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| **Michael Ewenson**<br>**Executive Director** | **Date of Release** |