ALBERTA

Report to the Minister of Justice and Solicitor General
Public Fatality Inquiry

Fatality Inquiries Act

WHEREAS a Public Inquiry was held at the The Law Courts

in the City (City, Town or Village) of Edmonton (Name of City, Town, Village), in the Province of Alberta,

on the 27 day of April, 2021 (year),

before Greg Lepp, a Provincial Court Judge,

into the death of Daniel Woodall (Name in Full) 35 (Age)

of Edmonton (Residence) and the following findings were

Date and Time of Death: Approximately 9:25 P.M. June 8, 2015

Place: University of Alberta Hospital, Edmonton, Alberta (where pronounced)

Medical Cause of Death:
("cause of death" means the medical cause of death according to the International Statistical Classification of Diseases, Injuries and Causes of Death as last revised by the International Conference assembled for that purpose and published by the World Health Organization – *Fatality Inquiries Act*, Section 1(d)).

Gunshot Wounds

Manner of Death:
("manner of death" means the mode or method of death whether natural, homicidal, suicidal, accidental, unclassifiable or undeterminable – *Fatality Inquiries Act*, Section 1(h)).

Homicidal

Introduction and Outline of the Report:

Two things must be front of mind for any reader of this report. First, Norman Raddatz, a man who no-one predicted, nor could have predicted, was capable of such a thing, murdered Cst. Daniel Woodall on June 8, 2015. Cst. Woodall's death was Norm Raddatz' fault. Second, although measures can be taken to reduce risk to police service members, the nature of their calling will always involve danger, including danger to life. Sadly, Claire Woodall will likely not be the last person to receive word late at night that a life partner has fallen.

In this report, I will first set out the purpose of this Public Fatality Inquiry and my role in preparing this report. Second, I will set out the circumstances surrounding the death of Cst. Woodall. Third, I will summarize conclusions reached by other organizations that have reviewed this case. Fourth, I will address whether additional steps can be recommended that might reduce the risk that this tragedy will be repeated in similar circumstances.

Purpose of a Public Fatality Inquiry:

The questions most often asked when a person has died in unusual circumstances are "how did it happen?" and "how can we prevent such a thing from happening again?". Public Fatality Inquiries are held to assist in answering these two questions.

Section 53 of the *Fatality Inquiries Act* mandates what I must, must not, and may do in this Report:

> 53(1) At the conclusion of the public fatality inquiry, the judge shall make a written report to the Minister that shall contain findings as to the following:
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> (a) the identity of the deceased;
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> (b) the date, time and place of death;
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> (c) the circumstances under which the death occurred;
>
> (d) the cause of death;
>
> (e) the manner of death.
>
> (2) A report under subsection (1) may contain recommendations as to the prevention of similar deaths.
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> (3) The findings of the judge shall not contain any findings of legal responsibility or any conclusion of law.
>
> (4) The report and findings of the judge under subsection (1) and any recommendations under subsection (2) shall not disclose any matters heard or disclosed in camera, unless the judge is satisfied that the disclosure is essential in the public interest.

One of the tasks of a judge holding an Inquiry is to find facts and thereby answer the question "how did it happen?".[1] Sometimes there are differing accounts of what occurred. Sometimes, the situation surrounding the death may have been chaotic. At times, there may be questions about credibility and reliability of evidence. In these situations, a judge is ideally placed to divine what occurred and report it to the public. She or he is accustomed to and experienced in sifting through evidence, and a judge has no stake in the making of factual findings.

In this case, I have confidence in the record put before me. Although Cst. Woodall's death occurred unexpectedly and in chaotic circumstances, the accounts of what transpired are consistent and there is no issue in this case with the reliability and credibility of the accounts I have reviewed. There is no challenge in determining what happened.

My other task is to make recommendations, if indicated, to prevent deaths in future in similar circumstances. In the case before me, three additional questions arise from this:

1. **What Comment Should be Made About Individual Mistakes or Missteps?**

Section 53 prohibits me from making findings about legal responsibility. The Supreme Court in the *Krever* Inquiry Case[2] had the following to say at page 23:

> Findings of misconduct should not be the principal focus of this kind of public inquiry. Rather they should be made only in those circumstances where they are required to carry out the mandate of the inquiry. A public inquiry was never intended to be used as a means of finding criminal or civil liability. No matter how carefully the inquiry hearings are conducted they cannot provide the evidentiary or procedural safeguards which prevail at a trial. Indeed, the very relaxation of the evidentiary rules which is so common to inquiries makes it readily apparent that findings of criminal or civil liability not only should not be made, they cannot be made.

In this case, there is no need to comment on any possible individual misconduct, in order for me to discharge my duties.

Additionally, the individuals involved in this case were not parties to the Public Inquiry before me. They had no opportunity to call witnesses or cross examine. It would not, therefore, be fair for me to make any unnecessary findings regarding any possible errors or missteps, criminal or otherwise.

Finally, as will be discussed below, an independent Alberta Serious Incident Response Team ("ASIRT") analysis was already done regarding potential criminal charges.

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[1] *Silverberg v. Landerkin*, 1998 ABQB 1105

[2] *Canada (Attorney General) v. Canada (Commission Inquiry on the Blood System)*, 1997 151 D.L.R. (4th) 1

2. What if Other Investigations Have Already Been Done?

As this report will detail, there have been several investigations and inquiries into the events of June 8, 2015. That is one of the reasons this Report is being delivered over six years after Cst. Woodall died. Customarily, a Public Fatality Inquiry is the last review to be done. This is because all inquiries into criminal and other liability should be exhausted first, so no person's interests can be put at risk in the fact-finding process at the Inquiry.

Here, the Operational Review conducted by the Edmonton Police Service ("EPS") was tasked with answering essentially the same questions facing me – What happened and how can we prevent it from happening again?[3] I find that the Operational Review was exhaustive and insightful. But there is no escaping the fact that the EPS is not independent. It has a stake in the finding of facts and it also has a stake in any recommendations for change.

The public is entitled to have a completely independent person, in this case, a judge, conduct essentially the same analysis in order to have confidence, or not, in the conclusions reached by the EPS. So, even though much of my analysis consists of reviewing the work already done by the EPS, there was still value in having this Inquiry.

In this connection, the words of the Supreme Court in *R v Faber* [4] are apt:

> [Fatality inquiries are] to assist and reassure the public by exposing the circumstances of a death. An inquiry dulls speculation, makes us aware of the circumstances which put human life at risk, and reassures all of us that public authorities are taking appropriate measures to protect human life. The inquiry also has an important role in ensuring that the justice system operates properly because it will investigate and review the work of the medical examiner and scrutinize the role that other part of the justice system may have played.

In this case the "other part of the justice system" is the EPS. Even if I find that the work of the EPS passes muster from an independence perspective, which, I find, it does, there is also value in having another set of eyes outside of the organization, determine whether anything was missed.

3. How Broad Should the Recommendations, if any, be?

The Alberta Court of Queen's Bench had occasion to comment on this in *Silverberg v Landerkin:*[5]

> The *Fatality Inquiries Act* does not restrict a judge in terms of the recommendations that he or she makes to prevent future deaths. However, the most effective recommendations that an inquiry judge can make are those that deal with the specific facts surrounding the death. If the death is a youth who

[3] In many situations giving rise to a Public Fatality Inquiry, many organizations took action that must be examined at the Inquiry. In this case, aside from Mr. Raddatz, all other individuals involved were members of the EPS. That is why the mandate of the EPS in its Operational Review and my mandate are essentially the same.
[4] *R v Faber*, [1976] 2 S.C.R. 9 or *R v Mercier*, 1997 ABCA 161
[5] *Silverberg*, *supra*, at para 13

> committed suicide while in the custody of the police, effective recommendations about how to deal with youths during their time in the custody of the police should be emphasized, not how he got there, whether it be in terms of the offence which he was accused of or the more metaphysical question of whether he had a caring upbringing. Moreover, when the recommendations go beyond the facts which can be directly linked to the death, there is a greater risk that the judge will exceed his or her jurisdiction which is to make recommendations to prevent future deaths.

I agree that the recommendations, if any, made should be informed only by the evidence before the judge holding the Inquiry. They should be narrow, not broad. If it were otherwise, the recommendations run the risk of being uninformed. In this case, for example, it would be outside the scope of the Inquiry to make recommendations addressing how Mr. Raddatz developed his racist and anti-authority views.

Circumstances Surrounding the Death:

1. **Cst. Daniel Woodall:**

The EPS recruited Cst. Daniel Woodall from the Greater Manchester Police and he served with the EPS and for the people of Edmonton for eight years until his tragic death on June 8, 2015. The last of his assignments was with the Hate Crimes Detail. He left behind his wife, Claire, and two young boys. His family has since moved back to the UK. Grateful to Edmonton for all the support they have received, and satisfied with the work done by the EPS, they now wish to be left in peace and cherish their memories of Cst. Woodall. They did not wish to participate in this Inquiry.

Cst. Woodall's memory has been honored in Edmonton in many ways. Thousands attended his funeral. Every year, the Calgary and Edmonton Police Services compete in the Woodall Cup, a charity soccer game created in his honor because he loved the game. The Cst. Daniel Woodall School in Windemere was named in his memory. The people of Edmonton will never forget him, his service to the community and the sacrifice he made.

After his death, ethnic and religious groups in Edmonton expressed heartfelt thanks through the media for the protection from hate Cst. Woodall afforded them. Many newcomers to Canada took their place along the streets to show respect as his funeral procession passed, knowing that he sought to keep Canada the welcoming place they chose as their home.

2. **EPS Hate Crimes Investigation Prior to June 8, 2015:**

In April of 2015, the EPS received a complaint from a man who said that Norm Raddatz was making Anti-Semitic comments about him in person and online.

The Southeast Division of the EPS contacted the Hate Crimes Detail for assistance. By mid-May, Hate Crimes had taken over the investigation. Hate Crimes learned that the complainant had a business relationship with Mr. Raddatz, who was, at the time, a contractor at the Millbourne

Mall. At one business related meeting, the complainant took off his fedora so that his yarmulke was visible. This prompted an immediate Anti-Semitic remark from Mr. Raddatz. His harassment of the complainant started immediately after and continued for about two years, on and off, until the complainant contacted police. Prior to his becoming aware that the complainant was Jewish, Mr. Raddatz had a casual personal relationship with him. They had been fishing, camping and hunting together.

The complainant was a part-time photographer and had a website and Facebook page relating to this occupation. Mr. Raddatz began posting Anti-Semitic remarks in the comments section of both, targeting both the complainant and his wife.

The messages posted by Mr. Raddatz were vile, crude and blatantly Anti-Semitic. Mr. Raddatz disparaged the complainant's photography, accused him, without basis, of spousal abuse, and insulted his wife in the worst ways imaginable. None of the messages, however, contained direct or indirect threats of violence.

From interviews Hate Crimes conducted with acquaintances of Mr. Raddatz, Hate Crimes was aware that Mr. Raddatz' relationship with his own wife and family had broken down. Mr. Raddatz was becoming angrier over time, he was drinking heavily, and he was missing work. Hate Crimes also learned that Mr. Raddatz expressed distrust of the authorities.

Because Mr. Raddatz knew where the complainant lived, the complainant became concerned about the safety of his wife who was often alone during the day.

Hate Crimes determined that there was sufficient evidence to justify the laying of a criminal charge of criminal harassment against Mr. Raddatz. I find this belief to be reasonable. Hate Crimes planned to arrest Mr. Raddatz on this charge and release him on a Promise to Appear in Court with conditions not to contact the complainant and his family.

The complainant told Hate Crimes that Mr. Raddatz possessed firearms, was a hunter and was a "pretty good shot". Mr. Raddatz had a Possession and Acquisition License (PAL) for firearms that expired in 2013. Records showed that he had registered six restricted firearms. He failed to renew the PAL, but the renewal notice sent to him was incorrectly addressed. It is possible he was unaware of the expiry of his PAL. Suffice it to say that there were grounds to believe that he possessed firearms on June 8, 2015.

Police checks determined that Mr. Raddatz had an outstanding bylaw warrant, some history with the City of Edmonton relating to the illegal parking of a recreational vehicle, and a very old drinking and driving conviction. Notably, he had no documented history of violence or misuse of weapons including firearms.

Before taking steps to arrest Mr. Raddatz, Hate Crimes approached some of his neighbors to ask if they were aware of any firearms risks. They were not.

Cst. Ray Wilson and Cst. Woodall went to Raddatz' residence about a week before June 8, 2015, planning to arrest him. He was not home. The two took that opportunity to speak to a neighbor

to obtain additional background information about Mr. Raddatz.

3. June 8, 2015:

On this date, Cst. Woodall and two other members from the Hate Crimes detail of the EPS, Cst. Wilson and Cst. Olekszyk, attended at the detached home of Mr. Raddatz. The three members planned to finish what they started a week prior. The goal, once again, was to arrest Mr. Raddatz that day on charges of Criminal Harassment and release him on a Promise to Appear in Court with conditions to stay away from the complainant and his family. Given what Hate Crimes knew about Mr. Raddatz, this method of compelling him to appear in court was reasonable. His detention in custody would not have been justified given what was known.

The Hate Crimes members were dressed in plain clothes with Csts. Woodall and Olekszyk wearing body armor over their shirts. EPS police identification tags were visible. All three members were armed with service pistols. They obtained the assistance of a patrol unit of two additional members prior to approaching the residence, Cst. Kelly Lang, who was with his canine, Police Service Dog ("PSD") Ryker, and Cst. Bill LeFurgey.

The three Hate Crimes members approached the front door to do a "knock and talk", hoping that they could convince Mr. Raddatz to turn himself in. From behind his front door, Mr. Raddatz, who was home alone, made it known to the police that he would not be coming out or opening the door. The members could see Mr. Raddatz through the living room window. He was arguing with them and demanded to see the arrest warrant, but he was not, at that time, posing security concerns. But Hate Crimes knew at this point that the arrest might become difficult.

If a person who is subject to arrest for a crime in Canada is in a residence and will not submit to arrest, it is necessary for the police to obtain a warrant from a judge or justice to enter the residence by force if they wish to effect the arrest. This type of warrant is known as a "Feeney warrant" bearing the name of the case[6] that determined the need for its being obtained. Cst. Wilson went to his unmarked patrol vehicle and arranged for a telephone application for this warrant.

The EPS members discussed having the Tactical Unit attend as well but no formal request was made. Hate Crimes Detail also considered talking to Tactical to see if Hate Crimes' proposed plan was in order, but were advised that Tactical did not ordinarily work on Mondays.

The plan to arrest using the Feeney warrant was approved by S/Sgt. Clover, who was not on shift, and Acting S/Sgt. Klenke, who was the Watch Commander in her position as Acting Staff Sergeant for that Division of the EPS.

These senior members of the EPS were told that weapons were not believed to be an issue.

Two other constables, Matthew Harper and Dan Roberts attended to assist with containment, essentially ensuring Mr. Raddatz did not exit somewhere other than the front door.

[6] *R v Feeney*, [1997] 2 SCR 13

Sgt. Jason Harley, the On Street Monitor, took the Feeney warrant to the scene. The On Street Monitor is a sergeant responsible for a squad on the street at a given time.

By now, eight members of the EPS and PSD Ryker were on scene.

The plan to execute the Feeney warrant was to start with an attempt to pick the lock on the front door and, if this failed, a ram to break that door. Sgt. Harley was a trained locksmith and was capable and authorized to attempt to pick the lock.

Sgt. Harley began attempting to do so. At the same time, members showed Mr. Raddatz the ram through the window and told him they would use it if he didn't cooperate. He didn't.

The lock pick attempt failed. Cst. Wilson opened the screen door and Cst. Harper struck the door for the first time with the ram, but it didn't break. At this moment, Sgt. Harley and Cst. Wilson, Cst. Olekszyk and Cst. Woodall were present at the front door area.

The second ramming attempt caused the door to buckle and Sgt. Harley believed something was blocking the door. At the same time, Cst. Olekszyk lost sight of Mr. Raddatz through the window.

Right after the door was struck a third time, shots were fired from inside the house. Bullets went through the front door striking Cst. Woodall and Sgt. Harley. Everyone who could do so retreated and sought cover including Sgt. Harley who suffered a minor gunshot wound to the back. Cst. Woodall, however, was "down" on the front step.

From the angle of shots fired, the EPS concluded that Mr. Raddatz, after first firing through the front door, must have exited his residence for a brief time and fired towards the vehicles where the police were taking cover. I conclude from the autopsy report that it is very likely Mr. Raddatz, while outside of his residence for this brief time, fired what by itself would be a fatal gunshot wound into Cst. Woodall while the constable was down on the front step. Cst. Woodall was almost certainly deceased shortly after Mr. Raddatz first shot him.

After reports of "shots fired" were broadcast, many members of the EPS who were on duty attended as did the tactical team. Mr. Raddatz continued to fire many volleys of shots over a ten-minute period. The EPS did not return fire. Fifty-five bullet holes were found in a single garage door across the street from his residence. Bullet holes were also found in some of the vehicles in the area. This gives an idea as to how many shots Mr. Raddatz fired in a short interval.

The residence then caught fire and burned to the ground. Firefighters could not put out the fire for safety reasons. As the fire burned, other gunshot sounds rang out. It is possible that ammunition in the house discharged from the fire. The house burned to the ground. A search of the residence and its contents later that night led to the conclusion that Mr. Raddatz started the fire, shot his dog and then shot himself to death.

There is evidence, from the shells recovered and the autopsy on Mr. Raddatz, that he fired at least three weapons: a 0.22 rifle, a 30.06 rifle and a shotgun.

Other Investigations and Reports:

Ordinarily, Public Fatality Inquiries are conducted after all other processes and reviews involving the death are complete. In the case of Cst. Woodall's death, there were many.

a. EPS Operational Review – October 21, 2015:

To nobody's surprise, the EPS engaged in a comprehensive review of this case to determine and document how the incident unfolded and to address any steps that could be taken to insure the proper handling of similar events in the future. As I previously indicated, the EPS review covered essentially the same ground I must.

The EPS tasked then Inspector (now Superintendent) Charles McIsaac to conduct the review. He worked with Supt. Steinke of the RCMP. Supt. McIsaac testified at length before me at this Inquiry.

After comprehensively reviewing the facts from statements taken from EPS members and members of the public, Supt. McIsaac, in his report, reviewed EPS policies engaged by the incident to determine whether they were followed and whether any changes to them should be made. He then assessed the training of the members involved to determine whether any improvements could be made in this area. The balance of his report related to issues arising from the incident that have no bearing on the death of Cst. Woodall so there is no need for me to comment on them.

The following recommendations, **relevant to the issue of prevention of deaths in similar circumstances**, were made and acted on by the EPS:

i. The initiation of scenario-based learning models covering Armed and Barricaded Persons and Level 1 and Level 2 incidents.

At the time of this incident, the EPS had a policy dealing with "Armed and Barricaded Persons and Critical Incidents Procedure". As will be discussed below, this policy was amended as a result of the Operational Review. Because of the change in policy, the above training was recommended and held. I find this to be a necessary and reasonable action.

ii. The inclusion in the next Staff Sergeant/Watch Commander retreat of tactical considerations for the entry into dwelling homes.

Planned entry by the police into a dwelling without consent triggers an additional legal requirement, namely the obtaining of a Feeney warrant as described above. This is so because an occupant has a very high expectation of privacy in his or her dwelling and has the right to be left alone unless there is an exigent public interest need for the authorities to enter or a judge or justice allows entry by issuing a warrant.

The EPS clearly also recognized that an occupant who is potentially dangerous, whether the police know or not, will more likely be triggered to harm someone if the police enter his dwelling without permission even if the police have a legal warrant to do so. Discussion of this tactical issue with senior members of the Service at their retreat makes sense.

iii. The elevation of the Hate Crimes Detail to Hate Crimes Unit.

Not surprisingly, the EPS has a defined hierarchical structure. On June 8, 2015 Hate Crimes was a Detail of constables reporting to a Sergeant who was not working full time in Hate Crimes. As a result of the EPS review, Hate Crimes was elevated from a Detail to a Unit now called the Hate Crimes and Violent Extremism Unit. That Unit now has a Sergeant in charge who reports to a Staff Sergeant. In short, the level of direct supervision of Hate Crimes has been strengthened with the goal of insuring day to day review of its operations by a more senior member of the EPS. This change is reasonable.

iv. A clearer definition of a "Critical Incident".

Before June 8, 2015 the EPS had a policy relating to "Critical Incidents" which are unusual occurrences that should be managed using negotiations and tactics. A hostage taking would fall into this category, for example.

Where a Critical Incident is found to exist, a specially trained Incident Commander is called in. Critical Incidents are defined as either being Level I or Level II depending on the severity of potential threats. There are a limited number of members of the EPS who hold the designation of Level I Incident Commander and fewer still who hold the Level II designation. In order to receive those designations, members must undergo rigorous and specialized training relating to negotiation and tactics.

None of the members of the EPS attending the Raddatz residence on June 8, 2015 engaged the Critical Incident Procedure. It was not entirely clear that the situation they faced was a Critical Incident, according to the procedure that then existed. The Procedure has been amended as a result of the EPS review and it is now clear that a situation like the one the police found at the Raddatz residence would be a Critical Incident and an Incident Commander, with his or her specialized training, would be in charge.

I will not give more detail with respect to the old or the new policy. To do so in a publicly circulated report would not be advisable since people in the position of Mr. Raddatz would be able to know, in advance, what would be facing them if they created a Critical Incident. Suffice it to say, I find the changes made to the policy and the training that followed the changes to be a reasonable step taken by the EPS.

v. Review the Use, Implementation and Approval of Technical Entry/Lock Pick.

The Operational Review concluded that delaying the use of the ram to gain entry into Mr. Raddatz house by first attempting a lock pick may have caused Mr. Raddatz to become more

agitated and/or to have more time to plan and execute an assault on the EPS members. It would have been less risky simply to use the ram from the outset where an upset homeowner is present inside and not cooperating.

Before the Operation Review, the Technical Entry Policy required members using this approach to obtain approval in advance from a Staff Sergeant and be licensed and trained in the area. After the Operational Review, the policy was changed to provide that lock picking is never an alternative to a breach entry under life threatening circumstances and must not be used where a subject in the property is not cooperative. I find this change in the policy to be reasonable.

vi. Implement a Search Warrant Execution Planning and Reference Guide with Policy Adjusted.

Before the incident leading to the death of Cst. Woodall, there was a policy in place dealing with entry into dwellings to arrest suspects which included the obtaining of Feeney warrants like the one obtained for Mr. Raddatz. The policy accurately set out the applicable law in this area and provided that a reasonable level of "sign off" was required before warrants were sought. It also set out a procedure, complying with the law, regarding the execution of the warrant. The Operational Review concluded that this policy was complied with on June 8, 2015.

Understandably, the EPS turned over every stone during the Operational Review to examine the gathering and sharing of information regarding risks posed by Mr. Raddatz. His previous history with the EPS, with other authorities including the City of Edmonton, his previous criminal record, the observations of his neighbors, the details of his harassing communications with the complainant and his involvement with firearms and weapons were all examined.

When entering a dwelling to effect an arrest or execute a search warrant it is, of course, important that all decision makers at the EPS be aware of risk factors when any warrants are obtained, when a plan of execution is formulated and when that plan is executed.

The EPS concluded that a more robust policy regarding the entry of dwelling houses was required to ensure that all decision makers were in possession of all reasonably conceivable risk related information. As an important example, some of the senior decision makers in this case were not aware that firearms could reasonably be expected to be in Mr. Raddatz' home. There was no policy in place prior to the incident requiring that this information be shared.

After the incident the policy was changed, most notably by requiring members applying for a warrant to enter a dwelling house, including a Feeney warrant, to prepare a check sheet called a "Search Warrant Execution Planning and Reference Guide". This document specifically referenced the risks outlined above, including the likelihood of firearms being present, mental health history of the subject, the subject's affiliation with groups promoting anti authority beliefs or attitudes and many others unrelated to this incident. [7]

[7] The Guide applies to both Feeney warrants and search warrants since the risks are common to both when a residence is to be searched. The Guide is relevant to this Report only insofar as it applies to Feeney warrants.

This change was, I find, required and reasonable to reduce the risk of events like the death of Cst. Woodall occurring in future.

I am more than impressed with the care and dedication the EPS showed in their Operational Review. Their motivation to do a creditable job was obvious. Aside from legal and public and internal confidence concerns, I have no doubt that, as a team, the EPS felt a deep emotional responsibility to their fallen comrade.

b. Fatality Review Board Review - April 27, 2016

On April 27, 2016 the Fatality Review Board, pursuant to section 33(2)(b) of the *Fatality Inquiries Act*, recommended that this Inquiry should be held in order to clarify the circumstances of the case and consider making recommendations that would prevent deaths in similar circumstances. The Minister of Justice and Solicitor General ordered this Inquiry under section 35(1)(a) and the Chief Judge appointed me to hold it under section 35(3).

c. Occupational Health and Safety Investigation – December 8, 2017

Because this incident resulted in the death of Cst. Woodall and an injury to Sgt. Harley, both on duty during their employment as workers at a worksite, Occupational Health and Safety investigated to determine whether there should be a prosecution or administrative penalty under the *Occupational Health and Safety Act.* Such proceedings generally address concerns about an employer, in this case the EPS, failing to look after the safety of its employees.

The conclusion was that no prosecution or administrative penalty was warranted.

d. ASIRT Investigation – June 14, 2018

The ASIRT exists to investigate independently situations like the death of Mr. Raddatz who died while technically in the custody of the EPS. The purpose of an ASIRT investigation is to determine whether there are reasonable grounds to believe that any police member committed an offense. If ASIRT reaches this conclusion, the case is then reviewed by the Alberta Crown Prosecution Service (ACPS) to determine whether charges should be laid and the case prosecuted.

ASIRT is staffed by former and active police investigators who are seconded to that organization. Since its inception, ASIRT has always had an Executive Director who is a former prosecutor with ACPS. The Executive Director of ASIRT is a Chief of Police under the *Police Act*.

The Raddatz investigation was referred to ASIRT by the Minister of Justice and Attorney General for this purpose pursuant to section 46.1 of the *Police Act*.

The Executive Director of ASIRT concluded, following the investigation, that there were no reasonable grounds or even reasonably suspicion, that any member of the EPS committed a crime. She concluded that at all times all members were acting in accordance with the law.

e. ASIRT Review of Edmonton Police Service Operational Review – June 28, 2018

The ASIRT review referenced immediately above relied on the investigation conducted by ASIRT itself. ASIRT was also contacted by the Edmonton Police Service and asked to review the EPS Operational Review, described above, to render an opinion as to whether, based on the additional information contained in the EPS investigation, there were reasonable grounds to believe any criminal offense was committed. The central issue in this investigation was whether the risk posed by Mr. Raddatz was known and effectively communicated to and considered by supervisors at the EPS.

After comprehensively reviewing the circumstances and the applicable provisions of the *Criminal Code of Canada*, the ASIRT Executive Director concluded that there were no reasonable grounds to believe that any members of the EPS had committed a crime and there was no need for further investigation in this regard.

Recommendations for the prevention of similar deaths:

As stated above, I find the EPS Operational Review was comprehensive, appropriately targeted and honest. The recommendations made and acted upon were reasonable.

It is axiomatic that risks faced by police are increased when they are dealing with persons of interest in their own dwellings. Risks are further increased where the person has antisocial beliefs and access to weapons including firearms.

The changes made as a result of the EPS Operational Review addressed these risks. But it is also important for the police to consider whether, in all of the circumstances, and in consideration of the risks, entry into the dwelling is the best course of action. Asked another way, was there a different approach that could have been used to arrest Mr. Raddatz given the known risks the police were facing in entering his residence without his consent?

Hate Crimes likely initially expected the arrest and release would be routine that day. Over the course of the afternoon and evening the situation escalated. It is not apparent anywhere in the evidence I reviewed that the EPS took a breath and considered taking a course of action other than the forced entry into Mr. Raddatz' residence.

Perhaps they could have withdrawn on June 8, 2015 and surveilled Mr. Raddatz to see if there was an opportunity over the following days to arrest him when he left his residence. Perhaps they could have contacted the one son he was still in contact with to see if he could talk some sense into his father. Maybe none of these options, or others, would have worked but they could have been considered.

Additionally, it is important to remember that Mr. Raddatz' spiraling was not known to the police nor did they know that he had amassed a considerable arsenal in his residence. It is entirely possible that a delay in his apprehension would have allowed him to carry out some sort of a plan that would have caused the death or injury of even more people. It is also possible that an unsuccessful attempt to arrest him, followed by a withdrawal by the EPS would have sparked some sort of irrational and dangerous action by him. We will never know.

I do not make these comments to fault the actions of the EPS that day. But it is only human nature to continue to pursue a goal, in this case the arrest of Mr. Raddatz, once that goal has been set, even if the means to achieve that goal become less acceptable over time because of unanticipated events. Supt. McIsaac did not disagree with this perspective when asked about it at the Inquiry.

It is therefore my recommendation that the EPS make a small change to the Search Warrant Execution Planning and Reference Guide.

When an EPS member determines that entry to a dwelling is an option for effecting an arrest, the Guide walks the member through all conceivable risks including those highlighted in this report. The member must check off whether each risk exists and describe it. This serves a two-fold purpose. First, it ensures that all relevant risks are considered and described. Second, it ensures that all risks have been communicated to senior members who have oversight responsibility.

I recommend that the Guide should include a section dealing with alternatives to the entry of the dwelling to effect the arrest. That section would ask whether alternatives exist and what they are. Considering the two-fold purpose of the Guide, such an inclusion would remind the member to consider those alternatives and it would also allow the supervising senior member to provide informed direction in consideration of those alternatives.

It is also my recommendation that the "Lawful Entry to a Dwelling House to Effect an Arrest Procedure" be amended to provide that entry should not be sought where less invasive alternatives to arrest reasonably exist. The Policy should also remind the reader that the option of such an alternative should be explored not only before initially considering entry to a dwelling but throughout the process of execution, in case the risks of entry escalate as they did here.

The EPS and the RCMP did excellent work in the Operational Review. I am not aware whether its conclusions were drawn to the attention of other policing agencies in the province. If they have not, they should be.

DATED March 14, 2022,

at Edmonton, Alberta.

Original Signed

Greg Lepp
A Judge of the Provincial Court of Alberta