

# POLICE INVOLVED DEATHS

## THE NEED FOR REFORM

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## POLICE-INVOLVED DEATHS: THE NEED FOR REFORM

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Thanks to the Law Foundation of B.C. for their support of this project.

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# **Introduction: Accountability for Police-Involved Deaths in Canada**

David MacAlister

## **Need for Accountability**

Police-involved deaths have attracted considerable media and public scrutiny in recent years. As a society, we value life, liberty and security of the person as core values worthy of constitutional protection. When government officials interfere with these core values, the call to publically account for that interference is understandably very significant.

In 2011, the RCMP reported the results of a poll that revealed many Canadians still had confidence in the RCMP; however, confidence levels were quite low in western Canada where a number of recent incidents attracted negative attention to the police force (CBC News, 2011a). In B.C., only 56 percent of respondents polled by the RCMP indicated they believed the RCMP was an accountable organization (Sherlock, 2011). Summarizing the report for the *Vancouver Sun*, Tracy Sherlock noted that only 57 percent of British Columbians believed the RCMP investigates public complaints appropriately and with transparency. The RCMP's own poll revealed serious deficiencies regarding public confidence in RCMP leadership and openness of communication with the public.

Mediocre public support for the RCMP in western Canada follows on the heels of several high profile incidents resulting in deaths at the hands of the police, many of these incidents involving the RCMP. In 2008, Raymond Silverfox died after being held in RCMP cells in Whitehorse, Yukon Territory, where he vomited 26 times over a 13 hour period without receiving medical attention. In 2007, Robert Dziekanski died during a taser incident involving the RCMP at Vancouver International Airport. In 2005, Ian Bush was shot in the back of the head by an RCMP officer while in police custody in Houston, BC. In 2004, Kevin St. Arnaud was shot to death by an RCMP officer in Vanderhoof, B.C. under suspicious circumstances. Additionally, numerous incidents involving RCMP officers

and city police officers mistreating individuals under their care have led to public distress over the actions of those who are supposed to be serving and protecting the public from harm.

Our society does not condone the killing of anyone. When those who have been authorized to use deadly force kill a member of the citizenry they have been charged with protecting, it arouses serious concerns. The capacity to use force is often seen as the core of the police role (Bittner, 1991). Not far below the surface of all police interactions with the public is the potentiality of the police imposing solutions and exerting their will through the coercive use of force to accomplish what they perceive to be desirable ends. It is the very fact that the police have the capacity to employ force where it is needed that calls for scrutiny into their exercise of force, particularly where it results in serious harm or death to those with whom they come into contact. Society has specifically allocated the police the right to use, or to threaten to use force beyond the authority given to the regular citizenry. To be perceived as legitimate, police use of force must be subject to open and transparent accountability.

### **Invisibility of policing**

Prior to the widespread availability of video cameras, much of the work of the police was invisible to the public. While police carry out much of their work in public, the wide-ranging discretion that has been allocated to them results in decisions that are best characterized as “low-visibility” (Goldstein, 1960). Police exercise their discretion in how to best resolve situations they encounter with very little oversight or accountability for their decisions.

The 1991 videotaped beating of Rodney King in Los Angeles California was a watershed event worldwide in the visibility of police decision-making and in the development of a new public attitude towards police violence, “the dramatic videotape gave new credibility to allegations of a sort that many people – including police officers – formerly dismissed as unbelievable” (Skolnick and Fyfe, 1993, p. 3). In Canada, the 2007 videotaped altercation between the police and Robert Dziekanski had a similar impact. However, in the intervening years, the advent of 24 hour news stations, the popularity of social media, and the huge popularity of YouTube as a video-sharing website combined to make public access to the video instantly possible (Goldsmith, 2010).

The heightened visibility of police wrongdoing that has been captured through the widespread use of video cameras and cell phone cameras by members of the public has transformed that public’s attitude towards the police. Police have lost control of their image management. The result has

been a decline in perceived police legitimacy and an increased demand for accountability.

### **Disparate impact on Aboriginals and marginalized populations**

While the number of Aboriginal Canadians dying through police involvement remains unknown, we do know that Aboriginal people are disproportionately represented throughout the criminal justice system. While they make up approximately 3 percent of Canada's populations, they make up 18 percent of provincial and federal prison admissions of sentenced offenders (Calverley, 2010; Perreault, 2009), and 21 percent of offenders sent to remand (Porter & Calverley, 2011). While there might not be any evidence of Aboriginal people dying at a higher rate than non-Aboriginals through police contact, their higher rate of police contact and jail admission results in high numbers of in-custody and police-involved deaths in comparison to the population at large.

The lack of available systematic information on Aboriginal deaths in custody was clearly identified by Hannum (2003) in a report prepared for the Native Courtworker and Counselling Association of B.C. That report revealed the difficulty in trying to identify the extent of Aboriginal deaths in police custody. Many agencies fail to identify race/ethnic background, causing the information to disappear into more general statistics on deaths in custody. The report noted that B.C. Coroner's data had revealed that, between 1993 and 2003, 60% of all Aboriginal deaths in custody occurred while in police custody; among non-Aboriginals, only 25% of in-custody deaths arise while in police custody (p. 4). The report goes on to note that amongst deaths in-custody in Vancouver during the same time frame, a greater proportion of Aboriginals were likely to be classified as "undetermined deaths" compared to non-Aboriginals (20% versus 8%). Accidents were ruled as the cause of death for 40% of Aboriginal cases, compared to 28% for non-Aboriginal. These figures just begin to paint the picture of Aboriginal deaths in custody. Despite calls for the collection of race-based statistics to give us a better picture of the extent of Aboriginal over-representation among police-involved death cases (Cheema, 2009), there appears to have been no move in recent years to gather such data.

The Manitoba Aboriginal Justice Inquiry (Hamilton & Sinclair, 1991) found that Aboriginal people are arrested and held in custody in circumstances where non-Aboriginal persons would either not be arrested at all or arrested but not held in custody. The Inquiry found that a Winnipeg police officer acted on the basis of racial stereotypes, engaging in the stop of an Aboriginal man (J.J. Harper) that was unnecessary and based on racialized motivations, ultimately resulting in the death of that man at the hands of



the police. Prejudice and discrimination against Aboriginals by the police in Canada has been alleged through several academic studies, including that by Havemann, Couse, Foster, and Matanovitch (1985), who found Aboriginal youth were less likely to receive police warnings than non-Aboriginals across the country. Similarly, in the same year, Harding (1985) found police were two to three times more likely to charge Aboriginals than non-Aboriginals for public intoxication in the city of Regina.

Differential charging practices are not confined to Aboriginal Canadians. The Ontario Commission on Systemic Racism (1995) found that some police officers act on the basis of stereotypes and discriminatory views of other ethnic minorities, particularly blacks. White accused were found to be more likely to be released by the police and if brought into custody, were less likely to be detained following a bail hearing. A pattern of police bias against racialized groups in Ontario was also identified by Mosher (1998).

Canadian data on the race and class backgrounds of those who die in police custody, or through police contact, is lacking. However, it can be noted anecdotally that many of those dying through police-initiated contact come from these backgrounds. Raymond Silverfox was an Aboriginal man from the Little Salmon Carmacks First Nation with deep family roots in the Whitehorse community (CBC News, 2011b). Robert Dziekanski was a working class immigrant seeking to start a new life in Canada (Braidwood, 2010). While Kevin St. Arnaud and Ian Bush did not come from disadvantaged backgrounds, many other individuals who have fallen at the hands of the police did. Frank Paul, a Mi'kmaq from New Brunswick, was dragged out of the Vancouver drunk tank, on a December 1998 night, by city police and left unconscious, "alone and cold" in a Vancouver alley where he succumbed to the elements (Davies, 2009). Police officers from the same city department shot and killed Paul Boyd, a man who suffered from bipolar disorder who was apparently suffering from a paranoid delusion when confronted on the streets of Vancouver wielding a bicycle lock chain. Nine shots were fired by city police, taking his life in 2007 (CBC News, 2007). Neil Stonechild was a Cree First Nations man who died on the outskirts of Saskatoon on a cold November night in 1990 (Wright, 2004). While evidence was inconclusive in the case due to inadequate police investigations, there was testimony that supported the contention that he had been picked up by the local police and released on the outskirts of town in what has come to be known as a "starlight tour" (CBC News, 2004; Rebar & Renaud, 2005)). Ten years later, in 2000, two more Aboriginal men were found frozen to death on the outskirts of Saskatoon; however, evidence of what led to these deaths failed to determine the precise circumstances, including whether police were directly involved. In that same year, Darrell Night, also a member of the Cree First Nation, was abandoned

on the outskirts of Saskatoon by local police; he survived to tell the story, ultimately resulting in the two white police officers being convicted of unlawful confinement (Brown, D.L., 2003).

### **The nature of police-involved deaths**

Despite the importance that many people attach to scrutinizing the phenomenon of police-involved deaths, little is known about its nature. There has been very little literature on the topic, particularly in Canada. What little is known comes from two main sources, official government sources, particularly government-sponsored inquiries, and academic studies.

In 2007, the RCMP itself published a report on in-custody deaths (RCMP, 2007). That report found that the majority of in-custody deaths occurred at the scene of a call rather than in police cells:

Over the period from 2002 to 2006, a total of 80 persons died in RCMP custody, or an average of approximately 16 I-CD [in-custody death] incidents per year. The leading cause of death was alcohol or drug overdose. The majority of subjects died at the scene of a complaint, which was most commonly a disturbance or drunk in public call, or in a hospital within 30 minutes of initial contact with the police (RCMP, 2007, p. 3).

That report revealed fairly consistent numbers of between 14 and 17 persons dying in RCMP custody over the 5 year period being analyzed. Of the 80 deaths, more than half (n=45) occurred in “E” Division (British Columbia). While British Columbia has a large proportion of Canada’s RCMP members (33%), its proportion of the total number of in-custody deaths (56%) exceeds that proportion by a fairly wide margin. The report revealed that almost a quarter of the deaths (19 out of 80) resulted from police officer-involved shootings. After alcohol/drug overdose deaths, being shot by the police was the second highest cause of death revealed by their findings.

Government-sponsored inquiries into police-involved deaths have been quite numerous in recent years. Typically, these inquiries have followed high profile police-involved deaths that have attracted a lot of public and media scrutiny.

<b>Police-Involved Death</b>	<b>Government Inquiry</b>
J.J. Harper (1988)	Aboriginal Justice Inquiry (Hamilton & Sinclair, 1991)
Neil Stonechild (1990)	Commission of Inquiry into Matters Relating to the Death of Neil Stonechild (Wright, 2004)
Dudley George (1995)	Ipperwash Inquiry (Linden, 2007)
Frank Paul (1998)	The Davies Commission – Inquiry into the Death of Frank Paul (Davies, 2009)
Crystal Taman (2005)	Taman Inquiry into the Investigation and Prosecution of Derek Harvey-Zenk (Salhany, 2008)
Robert Dziekanski (2007)	Braidwood Commission on the Death of Robert Dziekanski (Braidwood, 2009, 2010) Commission for Public Complaints Against the RCMP – Police Investigating Police (Kennedy, 2009a, 2009b)

The value of government commissions as mechanisms of accountability has been the subject of some skepticism. Official government inquiries or commissions typically add another layer of accountability on top of pre-existing accountability structures. One can clearly see the humour that could attach to the Ontario Law Reform Commission’s (1992) decision to inquire into, and prepare a report on, public inquiries. Essentially, it was an inquiry into inquiries. However, the value in public inquiries has been clearly identified in the academic public policy literature. Commissions of inquiry have value for the wide-ranging investigative authority they may be given, which enables them to uncover facts concerning matters of substantial public importance (Centa & Macklem, 2001). In addition to their investigative capabilities, Centa and Macklem note that commissions of inquiry have an ability to inform and educate citizens in a way that is superior to alternative governmental approaches. This view echoes Roach (1995) who has asserted that public inquiries can be effective accountability mechanisms, particularly in addressing potential avenues for organizational reform.

Each of the inquiries identified above followed similar formats. They conducted an assessment of past events through formal hearings, and they addressed the broader social and organizational context within which the events giving rise to the inquiry unfolded. This mirrors the approach taken

in many other public inquiries (Roach, 1995). Such inquiries tend to refrain from placing blame directly on any single individual(s), but rather concentrate on the need for reform within the police agencies in question to prevent future incidents of a similar nature from arising.

A common element in all of the reports prepared by the various commissions of inquiry into police-involved deaths has been criticism of the way in which investigations of police conduct are carried out. All of the more recent inquiries produced recommendations that the way in which investigations of police-involved deaths are carried out must be altered to ensure enhanced transparency and legitimacy, either through increased civilian involvement (see, eg. Kennedy, 2009a), or through genuine civilian investigation, taking control of these investigations out of the hands of the police (see, eg. Braidwood, 2010; Davies, 2009; Salhany, 2008).

Government inquiries into police-involved deaths have typically followed incidents in which the police officers involved in the incident used a questionable level of force (Harper, George, and Dziekanski), involved the possibility of police bias against an Aboriginal victim (Harper, Stonechild, George, and Paul), or involved allegations of inadequate investigation of the officer(s) involved, or preferential treatment being given to the police. This latter concern was raised in all of the inquiries (Harper, Stonechild, George, Paul, Taman, and Dziekanski).

Academic studies looking into the nature of police-involved deaths in Canada have been very rare. A major study on in-custody deaths in Ontario was produced by Wobeser, Datema, Bechard and Ford (2002). Their research looked at deaths both in prison facilities as well as police cells. Relying on coroner's data, they found there were 308 deaths between 1990 and 1999 in the jurisdiction under study. Of this group, 58 died in police cells. They found that the largest number of police custody deaths involved suicide by strangulation (n=26); a further 21 detainees died from drug or alcohol toxicity. A small number were found to have expired from natural (n=6) or other causes (n=5). This study concentrated on identifying the causes of death with a view to identifying possible avenues of prevention. Research by Kara and MacAlister included in this volume supplements the Wobeser study by providing a detailed look at the deaths of women in police custody in the province of Ontario between 1992 and 2006.

### **Coroner's Data**

The coroner's services in British Columbia and Ontario have recently provided some information regarding the nature of police-involved deaths (B.C. Civil Liberties Association, 2010a). These data provide interesting contrasts between the two jurisdictions.

Coroner’s data from Ontario revealed there were 316 police-involved deaths between 1992 and 2007. In that same time period, there were 267 police-involved deaths in British Columbia. While the absolute numbers for Ontario were slightly higher, the significant difference in population for the two provinces reveals that people are much more likely to die through police-contact in B.C. compared to Ontario. Using census population estimates of 13,210,700 for Ontario and 4,531,000 for B.C. in 2010 (Statistics Canada, 2010), the rate of death through police involvement in Ontario is 1 death for every 41,806 people compared to 1 death for every 16,970 people in B.C.

Coroner’s data from British Columbia and Ontario show that between 1992 and 2007, about one third of police-involved deaths occurred in police cells. Another quarter of all police-involved deaths in the two jurisdictions involved an auto pursuit. The data provided from the two jurisdictions did not allow direct comparisons regarding other circumstances of death. The B.C. data revealed that a significant number of individuals died through a police shooting (n=35 or 13.1%). The Ontario data did not reveal how many individuals died as a consequence of being shot by the police; however, 83 (26%) died from what the coroner classified as “police action” which presumably includes shootings and other forms of police intervention. In both jurisdictions, a number of cases involved some form of police-involvement, but even the general circumstances of the deaths were not identified. This included 96 unspecified cases (36%) in B.C. and 46 cases (14.6%) from Ontario where the subject was under arrest but not in jail.

	Circumstance of Death			
	British Columbia		Ontario	
	Number	Percentage	Number	Percentage
Police Custody - Cell/Lockup	77	28.9	107	33.9
Police Auto Pursuit	59	22	80	25.3
Other	131	49.1	129	40.8

The findings from Ontario are explored in more depth in the article by MacAlister in the present volume.

**Responding to police-involved deaths**

After a death occurs in police custody, attention often turns to matters of accountability. How can those directly affected by the death obtain an account of what has happened and seek justice? The family of the victim

often searches in vain to find an effective means through which to address the outcome.

Historically, all deaths in police custody have resulted in a mandatory coroner's inquest. Each province has enacted legislation governing the conduct of inquests. In British Columbia, the purposes behind an inquest are partly set out in s. 38 of the *Coroners Act*. These are to (1) ascertain the facts relating to a death, in particular to identify the deceased and understand how, when, where and by what means the death arose, (2) make recommendations that may prevent future deaths in similar circumstances, and (3) satisfy the community that the death is not being ignored, concealed or overlooked (Ministry of Public Safety and Solicitor General, 2011). In that province, all in-custody deaths must be the subject of an inquest unless the chief coroner dispenses with the requirement.

Coroner's inquests are neutral inquiries into the circumstances of a death. They do not seek to assign blame or recommend charges where there is evidence of wrongdoing. The inquests themselves do not question or criticize the quality of the investigation into the death. Additionally, the family of the deceased is not provided with legal counsel for the inquest, although they may retain private counsel. These aspects of inquests have left some feeling they fail as a meaningful forum through which to provide accountability (see, eg. the comments of Ian Bush's mother: B.C. Civil Liberties Association, 2007).

### **Criminal Investigation**

Historically, the police have been responsible for investigating themselves after it has been alleged that a police officer has engaged in wrongdoing. Often, this has been done by a professional standards unit or internal affairs unit within the same police department in which the alleged wrongdoer worked. The conflict of loyalties, both real and apparent, which prevail under such a system renders this an unacceptable approach to accountability (B.C. Civil Liberties Association, 2010b).

For many years, jurisdictions in the UK have recognized this conflict and rectified it with the use of independent investigation agencies. Wood's chapter in this volume looks at these developments to identify whether there are lessons to be learned from those jurisdictions. There certainly appears to be considerable merit in moving to an independent investigative agency, particularly for the investigation of serious incidents resulting in death or significant harm at the hands of the police.

In Canada, the first attempt to develop a civilian investigative agency to investigate police-involved deaths and other potential crimes occurred in

Ontario, where the Special Investigations Unit (SIU) was established in 1990. That organization investigates all cases involving incidents where it is alleged that municipal or provincial police have caused death, serious injury, or a sexual assault. The experiences of that organization are discussed in the present volume by a former Director of the Special Investigations Unit, André Marin. Additionally, in a separate chapter of this volume, Gareth Jones, a former investigator with that agency provides insights from working in SIU in order to identify what investigative agencies should avoid in the future.

The move towards civilian investigation appears to be a well-established trend in Canada. Several of the commissions of inquiry have called for this development (Braidwood, 2010; Davies, 2009; Salhany, 2008). The extent to which these developments have played out in a concrete way are tracked by MacAlister in a chapter in this volume.

### **Civil Suits**

Since the coroner's process and criminal investigations have typically failed to provide meaningful responses which hold police officers and their agencies accountable for police-involved deaths, some individuals have resorted to civil litigation as a means to find justice. A developing body of case law has found police officers and their employers civilly liable in a wide range of circumstances involving both intentional torts and negligence (Ceyssens, 1994).

The police are under a legal duty to take care of persons in their custody. Their duty is enhanced where a person is intoxicated or in need of medical care. There is an obligation on the police to protect those under their care from undue risks. This includes ensuring there is adequate surveillance of those being held in police cells, and extra steps must be taken where there is good reason to believe a detainee is a suicide risk. Police must also ensure they carry out other aspects of their job in a non-negligent manner. For example, liability will attach where the police negligently engage in an auto pursuit or fail to safeguard the public from dangerous situations they have attended. In some cases, the police will also be civilly liable for the intentional infliction of force in circumstances where such force is deemed to be excessive.

A number of roadblocks act as impediments to using the civil courts as a means of ensuring accountability. Civil litigation can be very time consuming and costly. While the ability and willingness of some lawyers to take on cases on a contingency basis may alleviate some of this concern, it does not eliminate the problem (MacAlister, 1999). The value of civil cases

as a mechanism of accountability for police wrongdoing is examined further by Holmes in this volume.

### **Need for Ongoing Reform**

Society must continue to call attention to the phenomenon of police-involved deaths. The need for ongoing attention was addressed in the UK by the creation of a Forum on Deaths in Custody, a body that has since evolved into an Independent Advisory Panel (IAP) on Deaths in Custody. Lessons learned from the Forum on Deaths in Custody in the UK are provided in a chapter in this volume by its former Chair, John Wadham, and his associate, Hannah Slarks. The current IAP on Deaths in Custody is Chaired by Lord Toby Harris. He has promised to play an important role in providing government with independent advice and expertise on a range of issues pertaining to deaths in custody in order to help shape future government policy (Independent Advisory Panel on Deaths in Custody, 2011).

In Canada, there is also a need for an independent advisory panel on deaths in custody, and police-involved deaths more generally. This is essential in order to increase attention on the death in custody phenomenon, and to provide alternatives to the way in which things are being done. The federal prison ombudsman has recently called for such a forum (Sapers, 2010), a call that was echoed by the B.C. Civil Liberties Association in its recent publication on police-involved deaths (B.C. Civil Liberties Association, 2010b). Many police-involved deaths are undoubtedly preventable. An advisory panel would ensure ongoing awareness of the phenomenon and provide a means through which a panel of experts could identify and promote best practices and policy initiatives which could prevent the needless loss of life in the future.



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# Deaths in police custody: Towards a typology

David MacAlister

## Introduction

In recent years, deaths in police custody have attracted considerable public scrutiny. The death of individuals in police custody is a cause of public concern for a number of reasons. The loss of human life in such circumstances can have an adverse effect on police-community relations, and raises concerns about accountability and public trust in regard to police actions which are largely invisible, particularly when they occur inside a police station. Police need to be held accountable for deaths arising among individuals under their charge. Analyzing these events helps to develop a better understanding of the death in custody phenomenon, thereby promoting trust between the police and the public. This research seeks to develop the literature in this area by canvassing the nature of the circumstances which typically give rise to the death of an individual who has been brought into police custody.

Deaths which occur in police custody usually receive enhanced scrutiny over other death occurrences. This is undoubtedly due to concern for the possibility of police impropriety in causing death. As a result, the coroner legislation in most jurisdictions compels a coroner's inquest into every death that arises in police custody. This provides a useful data source for examining this phenomenon (Pelfrey and Covington 2007).

Past research in this area has suffered from serious drawbacks. Pelfrey and Covington's (2007) research employed five case studies. While it provided rich data, it suffered from its small sample size which leads to concerns about the generalizability of their findings. Wobeser and her colleagues (2002) analyzed Canadian coroner data on in-custody deaths, providing aggregate data over a fairly long period of time (1990-1999) within a fairly large jurisdiction (Canada's most populace province: Ontario). However, this research looked at provincial and federal prison deaths in addition to

police custody deaths, amalgamating the data then looking at case characteristics. This resulted in an interesting quantitative overview of a large sample (n = 308); however, it lacked the richness associated with a focus on police custody deaths alone, a phenomenon which may differ from other forms of in-custody deaths.

Like Wobeser et al.'s (2002) research, the present study aims to look at the causes of death arising in custody in Canada's most populous provincial jurisdiction. However, it focuses exclusively on deaths in police custody and integrates a quantitative summary with a qualitative review of the files. In addition, this article proposes a tentative typology of deaths in police custody which should provide a useful analytical tool for future theoretical development in this area.

## Methods

Coroners and medical examiners do not routinely publish or publically disseminate details of information gathered regarding in-custody deaths. Pursuant to an access to information request, the Office of the Chief Coroner for Ontario provided detailed information regarding deaths in police custody in that jurisdiction from 1992 through 2007. Each death in police custody during those years resulted in a coroner's inquest. The Chief Coroner's office provided detailed information on each inquest, including the Coroner's jury verdict, and the presiding Coroner's explanation of the verdict where one was provided. Deaths occurring in actual police custody and those arising in circumstances where the police were attempting to bring individuals into custody were included in the data.

File data regarding the death of people in custody involving all police agencies in Ontario were included. In that province, inquests are required under the authority of the *Coroners Act*, which requires:

- s. 10(4) Where a person dies while detained by or in the actual custody of a peace officer... the peace officer or officer in charge of the institution... shall immediately give notice of the death to a coroner and the coroner shall issue a warrant to hold an inquest upon the body.<sup>1</sup>

In Canada, coroners are an adjunct to the criminal justice system. They do not adjudicate guilt; neither do they make recommendations with regard to the appropriateness of charging decisions. In Ontario, the Office of the Chief Coroner assigns a coroner to preside over each individual inquest. All

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<sup>1</sup> Ontario Coroners Act, RSO 1990, c. C.37

coroners are medical doctors in this jurisdiction, unlike some other Canadian jurisdictions.<sup>2</sup> They are responsible for conducting a supposedly neutral inquiry into the circumstances surrounding a death. When an inquest is conducted, it involves a jury composed of five members, which listens to evidence, makes a factual determination as to the circumstances of death, and also makes recommendations to avert future recurrences of a similar nature.

This research used the results of coroner's inquests to gain insight into the occurrences. The file data provided a rich source of information that was readily quantifiable, and also sufficiently detailed to permit a nuanced inquiry of the circumstances of the various deaths through close examination of the various files.

The units of analysis for this research were all individuals who died while in police custody in Ontario between January 1, 1992 and December 31, 2006. While some files pertaining to deaths arising in 2007 were available, it appeared that some inquests for deaths in that year had not been completed by the time of the information access request. Accordingly, files from that year were excluded from the analysis. This research does not include those individuals who died in other in-custody contexts in Ontario, such as those in provincial jails or in that province's federal penitentiaries. This research spans a full 15 years of police-involved deaths. A decision was made not to look at earlier deaths since it is inevitable that the nature of the death-in-custody phenomenon has changed over time, and the researcher wanted to address issues of contemporary significance. The coroner's files revealed a manageable number of incidents over the time period in question, negating the need to employ a sampling technique.

The decision to rely on coroner data, rather than other possible data sources, was made for a number of reasons. Presumably, Ontario's coroners do not have a vested interest in colouring the circumstances surrounding a death in police custody in order to protect the reputation of the police. Accordingly, coroner's data can be expected to be more neutral in their characterization of incidents than one would expect police data to be. In Ontario, all coroners are medical practitioners; none of them are former police officers. Another possible data source is newspaper accounts. However, their use was rejected due to the significant influence the police

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<sup>2</sup> Some other Canadian jurisdictions, such as British Columbia, do not require coroners to be medical practitioners and have, in fact, frequently used former police officers to fill the role of coroner, including the position of Chief Coroner.



exert over the release of information to the news media, thereby potentially biasing the neutrality of newspaper accounts (Ericson, Baranek and Chan 1987; Ericson, Baranek and Chan 1989). Since every in-custody death results in a coroner's inquest, coroner's data are a highly valuable source of information regarding deaths in police custody. While at least one critic of coroners has maintained that coroners rarely provide sufficient information about the circumstances surrounding a death to satisfy the desire of the victim's family to understand what led to the death (Beckett 1999), as a source of data coroner's findings have also been noted to be "neutral" and "valid", forming a new "untapped resource" of information on deaths in police custody (Pelfrey and Covington 2007, p. 68). In some cases, the files are quite detailed. Each file in this study was reviewed, and data of interest was extracted and inputted into a data management program.

### **Results - Case Characteristics**

A total of 113 individuals (103 men and 10 women) died in police custody in the province of Ontario between the start of 1992 and the end of 2006. Some minor fluctuations appear in the number of deaths from year to year, ranging from a high of 12 in 1992 to a low of only 2 in 2006 (see Figure 1). The trend shows a decline over the 14 year period, revealing a mild negative association between year and number of deaths ( $r = - 0.67$ ). However, this trend has actually fluctuated rather than shown a consistent decline (see Figure 1). The average age of the males in the sample was 38.6 years, and for females it was 33.1 years. While the differences in means do not quite approach statistical significance ( $t(111) = 1.452, p \leq 0.15$ ), it is apparent that the women in the sample were, on average, a little younger than the men. Perhaps the small size of the sample of women contributed to the lack of significance in the results.

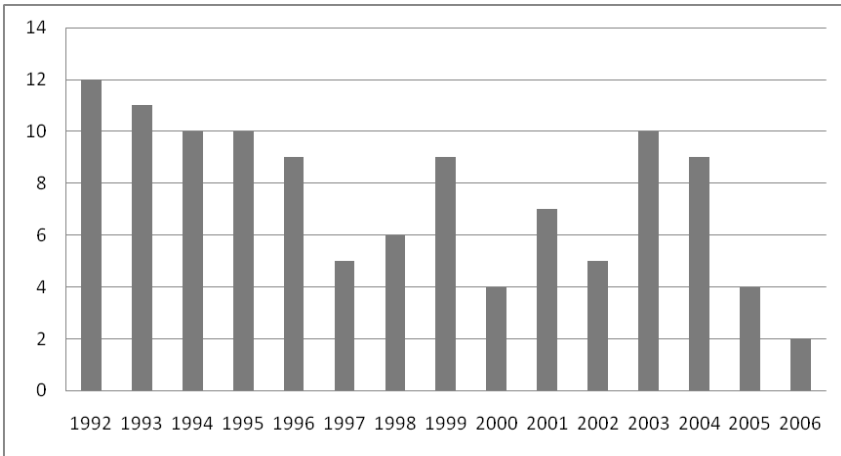


Figure 1. Number of Deaths in Ontario Police Custody by Year

The individuals who died in police custody met their demise in a number of different locations. About half of them ( $n = 55$ ) died in police cells. (see Table 1). Clearly, addressing the number of deaths in police cells is an important matter for those concerned with deaths in police custody (Krames and Flett 2005; Norfolk 1998). However, since half of the deaths in custody occur outside holding cells, the development of policy in this area must take this into account, accommodating the various locations in which deaths arise. It should be noted that this sample did not include police-involved deaths outside custody, such as most police-involved shootings, and motor vehicle incidents arising before the suspect was apprehended.

Location	Number	Percentage
Police cell	55	49
Police station	8	7
Police car	2	2
Ambulance	5	4
Hospital	11	10
Street	16	14
Home	8	7
Other	8	7
Total	113	100

Table 1. Location of Death

A distressed in-custody detainee may die at the scene of their initial encounter with the police. Eight died in their own home. In addition, one individual died in a homeless shelter, one person died in an apartment lobby, another died in an airport, two others in a washroom, and one in their own backyard. A detainee may become ill or injured and pass away en

route to hospital or after their arrival at that location. In this sample, five died in an ambulance en route to a hospital, while another eleven died in a hospital. Two detainees died in a police car, while eight people died in a police station, but not in police cells.

Individuals died in police custody from a number of causes. Coroners classify the cause of death as falling into one of five categories: homicide, suicide, accident, natural, and where the cause is unclear, undetermined (Parai, Kreiger, Tomlinson and Adlaf 2006). During the study period, almost half of those dying in police custody (52 of 113) were found to have died from an accidental cause (see Table 2). Over a quarter of the subjects ( $n = 33$ ) were found to have committed suicide. Of the remainder, 18 were found to have died from natural causes and a handful each were categorized as a victim of homicide ( $n = 4$ ) or undetermined ( $n = 6$ ). The ruling made at the inquest only tells a small part of the story behind an individual’s death. A more detailed analysis reveals a wide variety of circumstances form the backcloth to these in-custody deaths.

<b>Cause</b>	<b>Number</b>	<b>Percentage</b>
Homicide	4	4
Suicide	33	29
Accident	52	46
Natural	18	16
Undetermined	6	5
Total	113	100

Table 2. Cause of Death

A large proportion of those individuals who died in police custody had drugs and/or alcohol in their system at the time. The category of “accidental” death makes up the largest and most diverse group of in-custody deaths. Almost two-thirds of this group ( $n = 32$ ) died as a result of drug or alcohol poisoning. If one includes the individuals categorized as dying from excited delirium induced by cocaine ingestion ( $n = 6$ ), almost three quarters of the accidental deaths can be directly linked to excessive drug or alcohol consumption (see Table 3).

<b>Manner of Accidental Death</b>	<b>Number</b>	<b>Percentage</b>
Drug/alcohol overdose	32	61
Excited delirium (w/ cocaine)	6	11
Positional asphyxia	3	6
Respiratory distress syndrome	1	2
Drowned during escape	1	2
Hit by car during escape	1	2
Car crash	1	2
Hanging	1	2
Brain injury	1	2

Undetermined/unclear	5	10
Total	52	100

Table 3. Accidents - Manner of Death

Of the 38 individuals (34% of the total sample) who died as a direct result of drug and/or alcohol ingestion, 12 were found to have died as a result of alcohol poisoning, 21 as a result of drug overdose, and 5 from the combined effects of drugs and alcohol. The number of individuals dying in police cells who have consumed excessive amounts of alcohol is a major concern for those interested in police custody deaths, discussed in more detail below.

People die from natural causes in a wide array of circumstances. It is to be expected that some individuals brought into police custody will pass away from natural causes. However, the stress associated with being brought into police custody undoubtedly has an impact on the numbers dying under such circumstances. Although only 18 of the 113 subjects in this study were identified as dying of natural causes, almost three quarters of these ( $n = 13$ ) died from heart failure. Many of these individuals were found to have had coronary artery or heart disease, which was undoubtedly exacerbated by the stress of arrest and booking. Of the remainder, one died from liver cirrhosis, one from a brain aneurysm, two from a seizure disorder and one was identified as dying from an undetermined cause.

Thirty-three individuals in this study died as a result of committing suicide. The clear majority of these individuals ( $n = 25$ ) died from ligature strangulation, typically as a result of hanging themselves in a police cell (see Table 4). A further five individuals overdosed on drugs, two stabbed themselves to death, and one individual jumped to his/her death.

Manner of Suicidal Death	Number	Percentage
Hanging	25	76
Drug overdose/poisoning	5	15
Stabbing/slashing	2	6
Jumping	1	3
Total	33	100

Table 4. Suicides - Manner of Death

A small handful of individuals were categorized as dying as a result of homicide. Each of these three individuals was shot to death by the police in a violent encounter.

### Results - Qualitative Findings

The raw data pertaining to deaths in police custody paint an interesting picture. However, it does not allow a sufficiently deep understanding of the

death in custody phenomenon to allow for critical analysis or proper policy development. To accomplish these goals, a richer understanding of the death in custody matter is required. To achieve this, an in-depth look at the various files was necessary, revealing a number of themes that intersect various issues historically noted in the death in custody literature.

### **Theme 1: Alcohol and Drugs**

The role of alcohol and drug consumption in police custody deaths has always been an important theme in the academic literature on police custody deaths (Giles and Sandrin 1992; Hopkins and Sparrow 2006; Karch and Stephens 1999). The police role brings them into frequent contact with individuals who have consumed alcohol or drugs. It should come as no surprise that a great many people brought into police custody have consumed alcohol and/or drugs, some of them in great quantities.

As noted above, a number of individuals were found to have died accidentally from excessive alcohol or drug consumption. However, alcohol and drugs play an even greater role in the loss of life in police custody than the initial review of the data reveals. A more detailed analysis reveals an even more pervasive impact of drug and alcohol consumption.

Among the ten women in the sample, four of them were found to have died accidentally, three from a cocaine overdose and one from methamphetamine poisoning. Among the remainder, two committed suicide, at least one of whom had an extensive history of alcohol and drug abuse. Three died of natural causes, one of whom had a history of alcohol and drug abuse. The final woman's cause of death was undetermined; however, she was brought into custody for public intoxication.

Forty-eight of the men (47%) were found to have died from an accident. Of these, the vast majority (n = 35) were specifically noted to have died from the effects of drugs and/or alcohol. Cocaine consumption was identified as a key factor in nine of these deaths. A narcotic overdose was identified in four of the deaths. Five of those identified as dying by accident suffered from methanol poisoning. Methanol, or methyl alcohol, is an unrefined toxic chemical often used in antifreeze, solvent or as a fuel. However, it is also consumed as an intoxicant at great risk to the user due its toxic effects. Prior research in Ontario reveals that at least half of those dying from methanol poisoning had taken the substance accidentally (Liu, Daya and Mann 1999). Deaths clearly attributable to excessive ethanol (regular drinking alcohol) consumption numbered only eight. All but one of these occurred prior to 1998, perhaps reflecting heightened sensitivity among police agencies in recent years to the dangers arising from booking highly

intoxicated individuals into police cells. An additional seven individuals died from consuming a combination of ethanol alcohol and a drug.

Thirty one men were categorized as having committed suicide. Among these, five died as a result of ingesting drugs that killed them. Within this group, one overdosed on digoxin, having been subsequently arrested for domestic violence; he subsequently died in hospital. One individual suffered from paraquat (gramoxone) poisoning (a herbicide). He was arrested in connection with a sexual assault but had ingested the substance prior to police contact. A subject died from methyl alcohol poisoning, having been witnessed to ingest gasoline anti-freeze following a domestic dispute. Another individual died from an overdose of amitriptyline, alcohol and other drugs. These were taken prior to a struggle with the police and after a day of drinking. The individual had a history of suicidality and was depressed at the time of his encounter with the police and paramedics.

The individuals who died as a result of suicide from a drug overdose may be differentiated from those who were found to have died accidentally from a drug or alcohol overdose. The suicide motivation held by the subjects militates in favour of treating the suicide by hanging/slashing cases together with the suicide by drug overdose cases, although there are obvious differences in the circumstances of these various incidents.

Of the remaining suicides (discussed below in the context of Theme 4), almost all hanged themselves, but eight were intoxicated by drugs or alcohol at the time of arrest and two others were arrested as part of a drug investigation. It was not uncommon to see the deceased identified in the inquest report to have a history of drug and/or alcohol abuse.

Fifteen men were found to have died from natural causes, many from heart failure. Among those dying from natural causes, at least ten had a history of drug and/or alcohol abuse or were intoxicated at the time of arrest or death.

## **Theme 2: Death by Natural Causes**

Heart failure is a common theme among those dying from natural causes while in police custody. Eleven of the fifteen males who died of natural causes in custody (and both of the women who died from natural causes) succumbed to heart failure. While individuals could die from heart failure at any time, and in any location, it is noteworthy that many of those dying from heart failure in police custody were fairly young. The median age in this group was only 49 years ( $\bar{x} = 51$ ;  $\bar{x} = 56.5$  for men and 45 for women), and the range was from 33 to 83. All but one of the subjects was 60 years of age or under. By comparison, 85% of individuals admitted to hospital

nationally for heart failure are over the age of 65 (Lee, Johansen, Gong, Hall, Tu and Cox 2004). Of the thirteen individuals in this sample dying from heart failure, at least eight of them had been identified as previously suffering from a history of heart or cardiovascular disease.

As noted above, many of those dying from natural causes had an extensive history of drug or alcohol abuse, or had just been arrested in an intoxicated state. Two of the subjects were noted to have been enduring alcohol or drug withdrawal at the time of their death. The experience of being arrested and processed by the police is undoubtedly a very stressful situation for most people. The combination of drugs or alcohol with a pre-existing coronary or cardiovascular disease, when combined with the stress of being brought into custody by the police appears to produce a very risky situation.

Of those who died from natural causes, but did not die from heart failure, two died from a seizure disorder, one died from liver cirrhosis, and the other apparently died from a brain aneurysm.

### **Theme 3: Dying Violently**

Some of those dying in police custody do so relatively peacefully. As noted above, heart failure can strike at any time and in any location, and individuals may lapse into cardiac or respiratory arrest as a result of toxicity arising from drug or alcohol consumption. These relatively non-violent deaths stand in marked contrast to the manner of death faced by many others in police custody.

Some individuals do not go willingly into police custody. Some attempt to evade the police by running away, or attempting to use their vehicle to avoid capture. Some of these encounters result in a violent death. Four individuals were shot to death in an encounter with the police. One individual attempted to evade capture by running away from the police and died after jumping into the Welland River. Another was hit by a car while fleeing from the police. Yet another individual attempted to evade the police, then slashed his own throat, killing himself. Several individuals struggled with the police then subsequently died, either by suicide or by natural causes.

The violent/non-violent distinction is not an easy one to draw in some cases. Accidental deaths and suicides have elements of violence in them. If one takes violence to mean the expression of physical force against oneself or another, there are many accidental and suicide deaths that meet these criteria. However, the presence or absence of violence is an important distinction that allows for a further analysis of in custody deaths. Violent deaths call for enhanced oversight since the death occurs in the context of

police control, and the spectre of deliberate police wrongdoing is omnipresent in such circumstances.

#### **Theme 4: Suicide in Cells**

Suicides in police cells are an important aspect of the death in custody phenomenon that has received special attention over the years. The arrest and detention of an individual is undoubtedly one of the most stressful events a person is likely to ever experience. The negative consequences attendant to being inducted into the criminal justice system can easily bring on feelings of shame and despair. It should come as no surprise that a number of individuals going through the booking process have thoughts of suicide. The large number of mentally ill and drug/alcohol addicted people coming into police cells are undoubtedly key factors behind the numbers of people killing themselves in police cells.

The monitoring of individuals in police lock ups is an important matter. In many police departments, police cells are not under constant, vigilant observation. The costs associated with constant monitoring militate against this in some smaller police lock ups, resulting in the need for periodic checks of those in cells and video-monitoring being used to fill in the gaps in surveillance. Since many people who are booked into police custody are highly intoxicated at the time, it should come as no surprise that many detainees fall asleep thereafter appearing motionless for extended periods of time. To the typical observer, it is difficult to ascertain whether a person is asleep, unconscious, or dead. Accordingly, many people who pass away due to extreme intoxication are not identified as being in distress until too much time has elapsed to allow for effective medical intervention.

Many individuals who commit suicide in police cells hang themselves. Indeed, one of the two female suicide subjects in this sample hanged herself in a police cell. This individual had been arrested for taking the family car without permission, a relatively innocuous offence. However, she had a history of alcohol and marijuana consumption.

More men in this sample died in police cells than in any other location. Of those dying in cells, the typical causes of death were death by self-inflicted hanging and drug/alcohol overdose. A total of 25 male individuals were found to have hanged themselves, 23 of them in a police cell, while the other two hanged themselves in a hospital after being taken there for medical care by the police. Many of the coroner's inquest reports pertaining to in-custody suicide by hanging deaths recommended a variety of preventive approaches to reduce the likelihood of this type of occurrence. Measures such as changing cell design, limiting detainee access to items capable of being used as a ligature, and changes to the surveillance level of



detainees were common in the inquest reports. It is interesting to note that the number of in-custody hanging deaths appears to have declined in recent years (see Figure 2). Correlating year by number of deaths revealed a mild negative correlation ( $r = - 0.35$ ) showing that the implementation of preventive efforts in recent years may have facilitated a reduction in the number of such deaths. If one excludes the two in-hospital deaths (one of which was in 2005), the association becomes even stronger ( $r = - 0.37$ ).

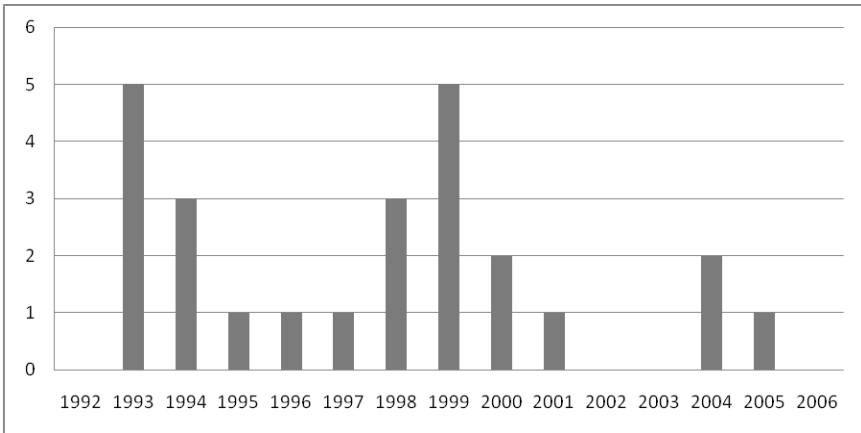


Figure 2. Number of Suicide Hanging Deaths in Custody by Year

### Discussion – A Typology of Police Custody Deaths

People die every day in a wide variety of circumstances. Death is a natural part of the life span, an inevitable end to every living thing. Even in the best of circumstances, death is a normal process. We can never find a social institution in which people will not die. Deaths occur from a variety of causes, some violent, others natural. If we accept this assumption, it is possible to use this to develop a collection of categories or types of circumstances resulting in death. Many deaths that arise in police custody appear to have similar characteristics, so they can be looked at together.

Using the various themes noted above, it is possible to create an outline of a typology of deaths in police custody that aids in the analysis of this phenomenon (see Figure 3). Typologies help us to organize complex phenomena, making it possible to bring together cases with common characteristics and distinguish cases from one another based on relevant differences. They present a classification system that is different from a simple definition of the phenomenon in question for a number of reasons. Typologies allow researchers to show the broad scope of the event under investigation, and allow one to adopt a particular level of analysis. Rather than concentrating on the specific biological or medical cause of death, this

typology focuses on the social level, addressing the relevance of human agency or actions. Typologies do not necessarily allow us to draw conclusions about the causes of the phenomenon in question; however, it is often possible to begin to think deeper about causes once the cases have been logically categorized.

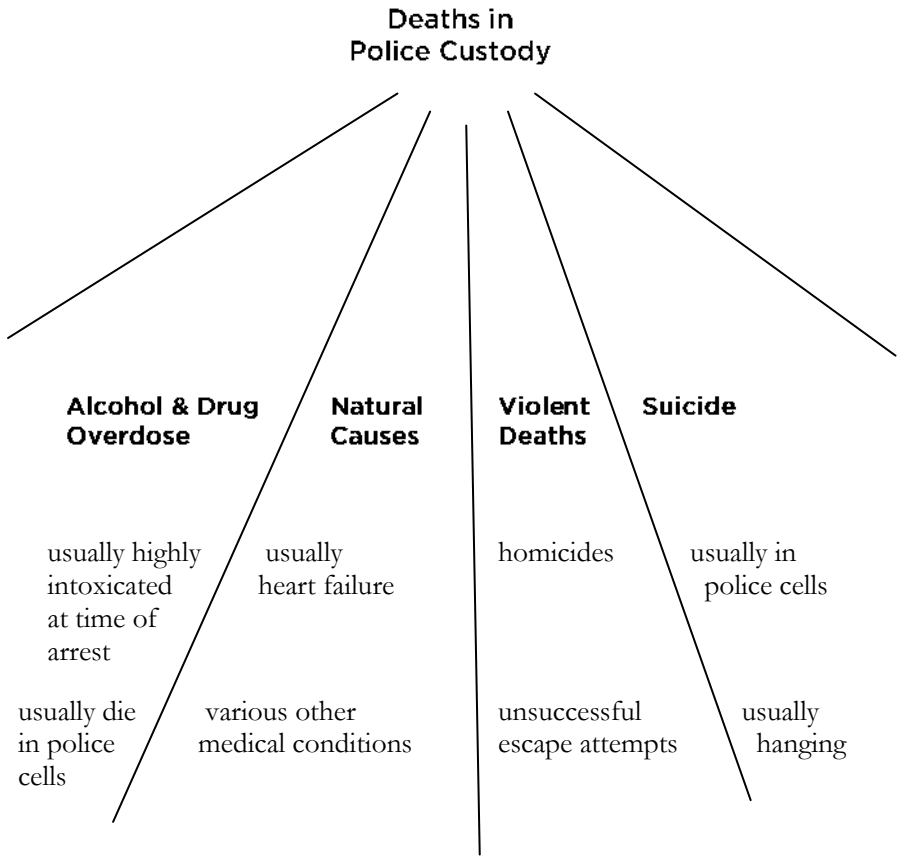


Figure 3. Deaths in Police Custody Typology

The key factors differentiating cases in this study were connected to the cause of death. The various themes that emerged from reviewing the cases showed that deaths arise in one of four major ways. Some subjects died from excessive drug or alcohol consumption. Others died from natural causes. Yet others are marked by the presence of violence. Yet others bring about their own death through their own conscious actions.

As noted in Theme 3 above, violence is an important factor present in many cases that cause us to look at such cases differently from non-violent deaths. Egon Bittner (1970) claimed the defining characteristic of the police is their capacity to use force to overpower resistance. While some level of force is implicit in all cases of the police taking individuals into custody, in some cases individuals go willingly, while in others they resist the detention or attempt to evade capture. These are the cases in which an individual citizen often ends up on the receiving end of police violence. Violence causing death could also arise at the hands of someone other than the police; however, in the present sample, none of the deceased died at the hands of another party such as a fellow inmate.

Suicide is a form of violence. The World Health Organization (2002) categorizes suicide as a form of self-directed violence in its three part typology of violence (along with interpersonal violence and collective violence). Deliberately self-inflicting the cessation of life on one's own person is analogous to the deliberate infliction of death-producing harm on another; however, for obvious reasons, it should be kept analytically distinct from such other forms of violence, and is treated accordingly in this typology proposal.

Accidental deaths cause considerable difficulty for analytical purposes. In some cases, they involve death arising from excessive alcohol or drug consumption. In other cases, they arise from some unfortunate confluence of events. For example, one of the deceased in the sample died as a result of jumping from a window in an attempt to evade capture by the police. Another jumped into a river to likewise elude the police. The first succumbed to the blunt force trauma associated with the fall, while the other drowned in his/her bid to escape. Both of these individuals died in circumstances characterized in the files as accidents; however, the circumstances clearly differ from an accidental overdose which was much more commonly encountered in the files. Accordingly, not all accidents should be lumped together; they are best viewed separately when they reflect very different dynamics. Many simply fell asleep and succumbed to the effects of excessive drug or alcohol intoxication, in effect dying in the context of police inaction. Others, especially those who died while attempting to escape, died at least in part as a consequence of police actions in attempting to take them into custody.

Self inflicted accidental drug overdoses should be treated as accidents, different from accidents resulting from attempts to evade the police, and also as a different type of case from deaths involving deliberate ingestion of drugs in a suicide bid. They also differ from deaths arising from natural causes. While they are both examples of fairly clear cut situations in which

the death is of a non-violent nature, they reflect different levels of responsibility on the part of the deceased. Since people die every day in all manner of circumstances, the odds are that, from time-to-time, people will succumb to disease or illness when by happenstance they are in police custody. These deaths tend to be the inevitable consequence of the life cycle itself, playing out in a random manner. Some deaths will appear a little less innocuous, resulting from deliberate, self-induced intoxication. Self-induced intoxication through alcohol or drug consumption may result in death where a person ingests enough of the intoxicant to suppress normal bodily functions such as respiration and cardiac functioning. These deaths arise through the victim's own human agency, but coroners are often reluctant to ascribe wrongdoing to the actor who may be addicted to the effects of the intoxicant that ultimately brings about their death, or the victim may simply have miscalculated the amount of the intoxicant they have ingested.

This typology is simply a model to help conceptualize the way in which police in-custody deaths arise. The types of circumstances that result in death have been fairly stable over time, although changing use of force tactics and the introduction of new policing technologies (neck restraints, conducted energy weapons, etc.) appear to be changing the way in which deaths have arisen over the years. The changing nature of preferred intoxicants (such as the growth in popularity of crack cocaine and methamphetamines), and the changing nature of the police station prison cell regime may be expected to alter the frequency with which different types of deaths are witnessed over time.

## **Conclusion**

The present study looked a large sample of in-custody deaths, spanning a considerable period of time. The results of this study are in keeping with the existing literature in that a multitude of factors are associated with deaths arising in police custody. However, given the large number of cases reviewed in the present study, it was possible to analyze the various cases with the hope of developing a typology of police in-custody deaths. This was accomplished by focussing on the presence or absence of violence in the various cases. It is hoped that this typology will facilitate future research that seeks to understand the phenomenon under investigation in greater depth. Ultimately, the goal must be to reduce the number of deaths in police custody through the development and implementation of preventive measures.

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# **Deaths of Women in Police Custody: An Examination of 10 Cases from Ontario**

Farzana Kara & David MacAlister

The death in custody phenomenon is a troubling trend that has become much too familiar in Canada and elsewhere. Much of the literature in this area has focused extensively on men. However, the gendered aspect of deaths in custody has been largely ignored, and is by and large absent from current scholarship. It has been suggested that the lack of information about women dying in custody is due to the relatively small number of deaths among women when compared to deaths among men (Collins & Mouzos, 2002). Despite the fact that women account for a small proportion of deaths in custody, this does not imply that it is an area not worthy of further study.

In this chapter, we present an exposition and analysis of deaths among women in police custody. Given the lack of research on deaths in custody where women are the principal focus, we employ a women-centred approach. All available files of coroner's inquests into the deaths of women in police custody in Ontario from 1992 to 2006 were reviewed. Data collected included age, cause of death, location of death, and history of drug and alcohol abuse. The circumstances surrounding the deaths were analyzed in order to determine whether women dying in police custody differ from their male counterparts. The majority of women died in police cells, where the women had been detained for relatively minor offences. Many of the women also had extensive histories of drug and alcohol abuse. In contrast to the men, violent altercations involving women and the police that result in death are infrequent. Many of the women's deaths in custody appear to be preventable.

Our present findings attempt to provide some insight into the nature of the death in police custody phenomenon as it affects women in Ontario, Canada. Existing literature on women's deaths in custody suffer from three main limitations: the focus has exclusively been on deaths in prison custody, the focus has been on suicide as the cause of death, and there have been small sample sizes (Collins & Mouzos, 2002). While our findings are based



on a small sample size, we do not merge data for prison and police custody deaths. Focusing on deaths within prison custody excludes deaths that occur in police custody and police-involved deaths. Police-related deaths account for a significant proportion of custodial deaths. The focus on suicide as the main cause of death is also limiting given that many of the custodial deaths can be attributed to other causes such as alcohol poisoning or drug overdose. In solely focusing on women who have died in police custody, this enables us to identify the potentially unique nature of deaths in police custody.

Most of the academic literature on deaths in custody either amalgamate data on women with men, or exclude women from the data entirely. Either approach has the unfortunate effect of contributing to the “invisibility” of women in police-related death research (Scraton & Chadwick, 1995), resulting in losing the ability to understand the true nature of women’s deaths in custody. The relative infrequency of deaths among women in custody may contribute to this invisibility. For example, research in Germany found only 1 of the 60 deaths in custody that were analyzed involved a female victim (Heide, Kleiber, Hanke, & Stiller, 2009), only 3 of 45 deaths in custody studied in Maryland, USA were women (Southall, Grant, Fowler, & Scott, 2008), and only 2 of 32 deaths in custody in the UK during 1994 involved women (Norfolk, 1998). The one study which has attempted to provide some insight into women’s deaths in police custody is Australian (Collins & Mouzos, 2002), leaving those in other countries to speculate on whether similar findings prevail across national boundaries.

In order to better understand women’s deaths in custody, an engagement with a theoretical framework is necessary. Many feminist scholars have addressed the issue of women in conflict with the law. Comack (1996) argues that situating women’s law violations within structural terms (as socialist feminism attempts to do) provides an understanding of the factors or conditions surrounding women’s lawbreaking which needs to be taken into account. While we cannot dismiss the fact that individuals possess power and make choices (“agency”), Comack notes that social power is unevenly distributed along race, class and gender lines producing systemic inequalities (1996, p. 31). Locating women in conflict with the law in structural terms then allows us to position this marginalized group of women within society. The structural barriers these women face gives us an idea of some of the hardships they experience.

## Methods

A retrospective analysis of Coroner's data was conducted to identify all deaths that occurred in police custody between 1992 and 2006. Pursuant to an access to information request, the Office of the Chief Coroner for Ontario provided detailed information regarding deaths in police custody in that jurisdiction from 1992 through 2007. Each death in custody during those years resulted in a coroner's inquest. The Coroner's office provided detailed information on each inquest, including the Coroner's jury verdict, and the presiding Coroner's explanation of the verdict. Deaths occurring in actual police custody, and in circumstances where the police were attempting to bring individuals into custody, were included in the data. A subset of this data was drawn, entailing all files involving women.

File data regarding deaths of people in the custody of all police agencies in Ontario were included. The inquests are required under the authority of the Ontario *Coroners Act* (RSO 1990, c. C.37), which dictates:

s. 10(4) Where a person dies while detained by or in the actual custody of a peace officer... the peace officer or officer in charge of the institution... shall immediately give notice of the death to a coroner and the coroner shall issue a warrant to hold an inquest upon the body.

The file data provided a rich source of information that was both quantifiable, and also sufficiently detailed to permit a qualitative inquiry of the various files. This research involved individuals who died while in police custody in Ontario between January 1, 1992 and December 31, 2006 resulting in a coroner's inquest. This did not include those individuals who died in other in-custody contexts, such as those who died in provincial jails, nor does it include those who died in Ontario's federal penitentiaries. This research spanned 15 years of police-involved deaths. A decision was made not to look at earlier deaths since it is inevitable that the nature of the death-in-custody phenomenon changes over time, and the researchers wanted to address issues of contemporary significance. Data was sought for those who died in 2007; however, due to the recent occurrence of these deaths, coroner's inquests had not been completed for many of them by the time of data acquisition. The coroner's files revealed a manageable number of incidents arising over the time period in question, negating the need to employ a sampling technique. Since the entire population of incidents covering the time period in question were secured, the researchers feel comfortable in asserting that no sampling error arises.

Coroner data was selected for a number of reasons. Unlike the police, coroners do not have a vested interest in coloring the circumstances

surrounding a death in police custody. Police agencies are usually concerned about protecting their reputation (Ericson, 1989; Ericson, Baranek & Chan, 1991; Ericson, Baranek & Chan, 1989), giving rise to concerns that police data may be of questionable veracity. Since every death in custody results in a coroner's inquest, coroner's data are a highly valuable source of information regarding deaths in police custody. While critics have argued that coroner's rarely provide sufficient information regarding the circumstances surrounding a death to satisfy the desire of the victim's family to understand what led to the loss (Becket, 1999), as a data source, coroner's findings have also been claimed to be "neutral," "valid" and a new "untapped resource" of information on deaths in custody (Pelfrey & Covington, 2007).

Each file contained a copy of the coroner jury's determination as well as an interpretation of it by the presiding medical examiner. In some cases, the findings were quite detailed. Each file was reviewed and data of interest was extracted and inputted to a data management program for analysis.

### **Overview of the Results**

The records indicate that between 1992 and 2006, 10 women died while in police custody in the province of Ontario. Compared to the number of male deaths over the same period ( $n = 103$ ), the number of women's deaths was low; however, each death was a tragedy in its own right. The deaths were spread out over the fifteen year period under study (see Figure 1). The age of the women at the time of death ranged from 20 to 53 years old, with a mean age of 33.1 years. This contrasts markedly with Statistics Canada's report on the mean age at death for the province at large, which was 77.5 years for women residing in Ontario in 2005 (Statistics Canada, 2008). In contrast, the average age of men dying in police custody during this period was 38.6 years.

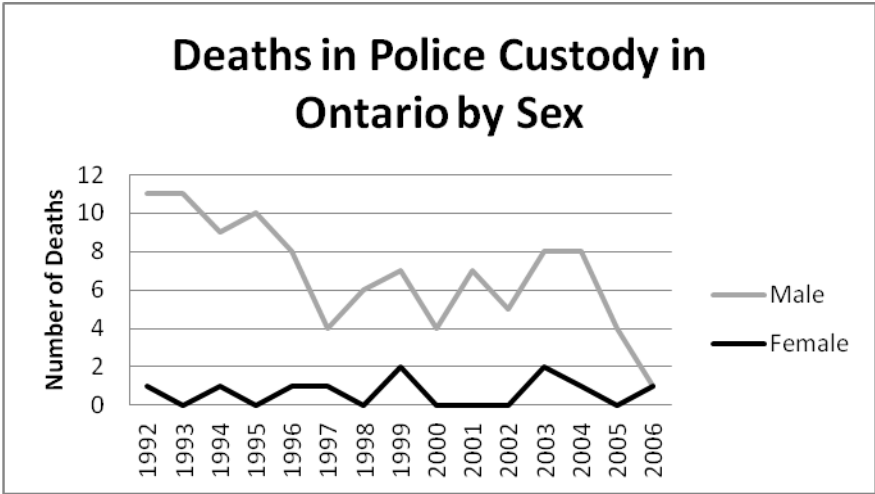


Figure 1. Number of Deaths in Police Custody by Year

**Location & Circumstances of Death**

The overwhelming majority (6 of the 10) of women who died in police custody died in a police station, all of whom died in police cells. Of the remaining women, one suffered heart failure at a police station and subsequently died in hospital and another one died in hospital due to a drug overdose. One died in her home, and the other died in the apartment lobby of her home. In contrast, only about one half of the men dying in custody during this same period did so in a police station.

Location of Deaths	Number of female deaths	Number of male deaths
Police Cells	6	49
Police Station	0	8
Home	2	8
Hospital	2	9
Police Car	0	2
Ambulance	0	5
Street	0	16
Other	0	7
Total	10	103

Table 1. Location of Death

The number of women in the sample who had a history of alcohol and/or drug abuse is extremely high. The data identified 7 of the 10 women had abused either alcohol and/or drugs. Of the 10 women, 3 had a history of drug abuse. In fact, three of the women died from a massive cocaine overdose, and one died from methamphetamine poisoning. There was no record of any history of drug abuse for one woman, but the coroner’s data

indicated that she had swallowed pellets of cocaine, and died as a result. Two of the ten women had a history of both alcohol and drug abuse, and one simply had a history of alcohol abuse. At the time of arrest, half of the women (n = 5) had consumed drugs, and one woman was arrested for public intoxication, having been arrested for this purpose on numerous prior occasions. The pattern of alcohol and drug abuse is similar for both men and women. Of the 103 men who died in police custody, 32 of them died from a drug or alcohol overdose. The data revealed that 16 of the men who died in police custody had a lengthy history of substance abuse.

### **Manner of death**

Coroners categorize the manner of death in Ontario as falling into one of five categories: homicide, suicide, accident, natural causes, and undetermined. In the women’s sample, the largest category was accidental deaths, with four of the women falling into this group (see Table 2). This was also the case for males (n=48). All of these women died from a drug overdose. Three of the women died from natural causes. One of these women was only 40 years of age, while the 2 women who died from heart failure were 53 and 37 years old respectively. The national data on heart failure reveals that over 88% of all women dying from heart failure in Ontario are over the age of 65 (Lee, Johansen, Gong, Hall, Tu, & Cox, 2004). The young age of the women in this sample who died as a result of coronary dysfunction is startling and raises concerns about the need for the police to be cognizant of prior medical conditions among those being detained. Three of the ten women died as a result of suicide. Two occurred in a police cell, as a result of self-inflicted hanging, while the other arose in the victim’s home, where the woman stabbed herself to death. One of the hanging deaths was ruled by the coroner as undetermined; however, the file is clear in indicating the woman died as a result of self-inflicted ligature strangulation. Her case carries all the hallmarks of a suicide, even if it was not identified as such by the coroner.<sup>3</sup>

<b>Manner of Death</b>	<b>Females</b>	<b>Males</b>
Homicide	0	4
Suicide	2	31
Accident	4	48
Natural	3	15
Undetermined	1	5
<b>Total</b>	<b>10</b>	<b>103</b>

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<sup>3</sup> In *Beckon v. Young* (1992), 9 O.R. (3d) 256, the Ontario Court of Appeal ruled that the required standard of proof of suicide is proof to a high degree of probability. This high standard may account for the coroner’s reluctance to rule Case 1 a suicide.

Table 2. Manner of Death

None of the cases involving women were the result of a homicide. It is noteworthy that in only one of the cases did the police use significant force against a woman victim (Case 4, below). That case resulted in the woman's suicide, as she stabbed herself to death following a violent encounter with the police. The manner of death for men does not appear to differ markedly from women with the possible exception of a small number of homicides being present in the men's sample.

## **Results – Case Studies**

### **Case No. 1**

A 43-year old woman was arrested by police for public intoxication. Prior to the arrest, the police were dispatched to a local coffee shop to respond to what was described as a disoriented woman. The woman identified herself to police, and indicated that she was currently living at the “Y”. Police suspected the woman was intoxicated by alcohol at that time. Unable to provide police with a proper address or contact number, police drove the woman to two separate locations in an attempt to leave her under the care of a responsible person. After these attempts failed, police arrested the woman and booked her into a cell for public intoxication. It was noted that the woman was loud and disruptive. She was removed from her cell and subsequently placed in another cell. She was later found hanging in that cell. Emergency response measures were immediately instituted and the woman was taken to a local hospital by ambulance. At the hospital, the woman was placed on life-support, and despite aggressive measures to resuscitate her, she died. The coroner's inquest deemed the cause of death to be hanging, but classified the death as undetermined rather than suicide.

### **Case No. 2**

A 44-year old woman was arrested on drug charges and taken to a police station where she was booked and placed in a cell under video surveillance. The woman became ill and started having a seizure. Officers attended to her immediately and called for an ambulance. Paramedics arrived and proceeded to give the woman basic life support after finding she had suffered from heart failure. She was transported to a hospital. They were met with an advanced life support crew en route to the medical facility and further attempts were made to revive her in consultation with an emergency physician. After arriving at hospital, some heart activity was temporarily recovered. However, heart function could not be sustained, and the woman was subsequently pronounced dead. The post mortem examination revealed that she died from a massive cocaine overdose caused by a ruptured baggie

of cocaine that she had swallowed. This death was ruled an accident. It was noted that the woman denied having taken any drugs to the arresting officers.

### **Case No. 3**

A 26-year old woman was taken into police custody after reports of her wielding a knife and acting in a bizarre fashion. She was a transgendered person who was born a man but had identified and lived as a woman for ten years prior to her death. Police arrived at the residence and subdued the individual, carrying the woman down several flights of stairs to the front lobby. At that time, no vital signs were present. Efforts to resuscitate the victim were made by the police, firefighters, and eventually an advanced-care paramedic. She was transported to the hospital where she was pronounced dead. A post mortem examination revealed the cause of death was inhalation of vomit brought about by cocaine poisoning. The coroner's report recorded the cause of death as cocaine poisoning, and the death was ruled an accident.

### **Case No. 4**

A 21-year old woman died in police custody after struggling with police. The young woman had an extensive history of mental health problems including depression, delusions, and hallucinations. She had been admitted to a psychiatric facility for a period of about four weeks after taking an overdose of medications. Subsequent to her discharge, she was regularly attended to as an outpatient by a psychiatrist, but she was said to continue to suffer from impulsivity, often abusing alcohol and failing to comply with medical treatment. Several officers were dispatched to a residence with preliminary information that there was a mentally disturbed person barricaded in a washroom, possibly armed with a knife. One officer tried to negotiate with the young woman through the bathroom door, but these attempts were unsuccessful. She refused to come out of the bathroom and denied having a knife in her possession. She also resisted the officer's attempts to enter by pushing against the door. The young woman eventually stopped responding to the officers. Fearing for her well-being, officers forced the bathroom door open and found the young woman lying on her back, brandishing a large knife and attempting to raise it towards her face. Oleoresin capsicum (pepper) spray was used on her and she released the knife. The young woman was dragged feet first from the bathroom by attending police officers. She resisted strenuously, and was handcuffed. Officers lifted the young woman and began to carry her upstairs while she continued to passively resist their efforts by lifting her feet. At the top of the basement stairs, the young woman's vital signs were absent. Officers immediately began to search for signs of injury to explain her sudden

collapse. At that point, they discovered a kitchen steak knife penetrating her left upper chest. The officers administered cardio pulmonary resuscitation and called for an ambulance. All further attempts at resuscitation, both prior to and after her arrival at a hospital, were unsuccessful. Postmortem examination revealed the presence of two stab wounds to her left chest, one superficial and one deep. The coroner determined the stab wound to be the cause of death and ruled this death a suicide.

#### **Case No. 5**

A 40-year old woman died in a police cell due to natural causes. She appears to have been taken into custody for public intoxication. The woman was a well known local street person who abused alcohol and perhaps other intoxicants. While in her cell she was assessed at one point by two different officers when the attending matron thought her breathing was odd. However, in the judgment of the officers she was simply in a deep sleep and snoring. She was checked every 15-30 minutes throughout her time in lock-up and was found with no vital signs present. Immediate resuscitative efforts were undertaken. These were continued for approximately one hour, during which time she had been transferred to a hospital. She was pronounced dead in the local hospital. The coroner's report deemed the cause of death to be acute streptococcal pneumonia meningitis.

#### **Case No. 6**

A 26-year old woman was arrested by police for assault on an outstanding warrant. At that time, she appeared to be under the influence of a "substance". She initially admitted only to have been drinking, but she later admitted to having using crack cocaine and swallowing an "8-Ball" just before her arrest. Her physical condition began to deteriorate while in police custody and she was transferred to a hospital by police cruiser. At hospital, she was attended to and provided treatment for a drug overdose. The young woman continued to deteriorate and was shipped to another hospital for further care, but her condition continued to worsen and she eventually died. Her cause of death was identified as methamphetamine poisoning, and it was ruled an accident.

#### **Case No. 7**

A 21-year old woman was arrested by police after she took a car without permission from the family home. She failed to stop for police, resulting in a vehicle pursuit, subsequent to which she was eventually arrested. She was incarcerated and remained in police cells over a weekend due to the serious charges she was facing. During this time, she was the only woman inmate in the facility. During her detention, she was in contact with several corrections officers and was frequently assessed by jail nurses. She gave a



history of alcohol and marijuana consumption for the months preceding her arrest, and medication was given to her for alcohol withdrawal. While she was initially categorized as a suicide risk by correctional officers, the medical staff at the facility disagreed with that assessment. Accordingly, policies pertaining to high suicide-risk detainees were not applied. The young woman was found hanging in her cell and was rushed to hospital where resuscitation temporarily restored cardiac activity. However, she never regained consciousness and died. The coroner determined the cause of death to be a ligature compression of the neck and ruled this death a suicide.

#### **Case No. 8**

A 53-year old woman was arrested by police for shoplifting. At the time of her arrest, the woman communicated to police that she was experiencing chest pain, had heart disease, and was on medication for congestive heart failure, although she did not have this medication on her at the time. The arresting officer observed an episode of shortness of breath while she was climbing stairs after being arrested and she was offered medical assistance at various times. Each time, the woman declined the police offer of medical assistance. During the night, a jail guard checked on the woman from time to time, assuming she was sleeping. His ability to carefully assess her may have been impaired by the fact that she had her coat wrapped around her body, covering her chest and lower face. The woman was found dead in her cell in the morning by officers on the day shift who were making a routine walk-through check. The state of her body suggested that she had been dead for at least one, if not several hours. The coroner determined the cause of death to be acute heart failure and ruled this death as natural.

#### **Case No. 9**

A 37-year old woman was arrested by police and charged with the alleged offences of uttering death threats and assault. The woman had a history of mental illness and was involuntarily admitted to a hospital at the time of the assault. She conveyed to a detention centre where she was placed in a special needs unit as she was considered at risk for suicide. The woman was to remain in custody until her court date. Six days later, a physician cancelled the suicide watch for the woman, but she remained in the special needs unit. Three days later, the woman failed to attend the nurses' station to receive her medication. A cell-mate attempted to wake her but was unsuccessful and alerted correctional officers who initiated an emergency response. Emergency services were summoned but it was determined that the woman had already expired. The coroner concluded the cause of death to be acute coronary thrombosis and ruled the death to be natural.

## **Case No. 10**

A 20-year old woman was apprehended by police at an airport upon being suspected of importing drugs into the country. She was taken to a hospital for medical clearance. The woman was discharged and taken back into custody. Once in police cells she developed severe pain and died in her cell. The coroner's report indicated that the woman had swallowed pellets of cocaine in Jamaica, prior to her trip back to Ontario. Leakage of drugs from these pellets caused toxicity. The cause of death was identified as cocaine ingestion and the death was ruled an accident.

## **Discussion**

A number of important findings arise from this review of women's deaths in police custody. While the number of deaths appears to be fairly small, they have remained constant over time. Despite continuing calls for change to the custodial regime as a result of coroner's inquests, the numbers have not dissipated. Women in conflict with the law continue to die in police custody despite ongoing efforts to eliminate such losses.

A large proportion of the women's deaths occurred in police cells. Women in cells died as a result of self-inflicted harm and as a result of the adverse effects of drug and alcohol consumption. Self-inflicted harm occurring in cells almost invariably involves the use of a ligature to strangle oneself. In the past, much of the focus on women's deaths in custody involved inquiries into suicide in cells (Lloyd, 1990; Ghazala, 2001). The present study shows that only two of the ten cases (Cases 1 and 7) involved a clear case of self-inflicted harm bringing about death in police cells. Both of these women had been intoxicated by drugs or alcohol at the time of arrest. Passing away in cells is as likely to result from the adverse effects of drugs and alcohol. Cases 2 and 10 reveal situations in which women overdosed on cocaine, succumbing to its effects in police cells.<sup>4</sup> One of these cases involved a woman apparently carrying drugs for trafficking purposes, and the other involved "bodypacking" drugs into the country, practices that have been previously cited as major causes of preventable in-custody drug-related deaths (Karch & Stephens, 1999). Several women also died from natural causes in police cells. Cases 5 (pneumonia), 8 and 9 (both heart failure) involved women dying as a result of what the coroner deemed to be natural causes. At least one of these (Case 5) involved a woman with a lengthy history of drug and alcohol abuse.

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<sup>4</sup> Death from drug intoxication has been identified elsewhere as a relatively recent phenomenon, not arising until the 1980s, coinciding with the recent period of increased cocaine abuse (Grant, Southall, Fowler, Mealey, Thomas, & Kinlock, 2007).

Mental illness appears to be a factor associated with several of the deaths in custody. The two in-cell suicide cases (Cases 1 and 7) clearly involved women with mental health problems. The other self-inflicted death case (Case 4) likewise revealed an unhealthy mental state at the time of death. In Case 3, the victim was acting in a manner described as “bizarre”, and Case 9 involved a woman with a history of mental illness. The literature has noted the high prevalence of dual-diagnosis (Mental Illness and Substance Abuse) among individuals who die in police custody (Best, Havis, Strathdee, Keaney, Manning, & Strang, 2004). These authors assert that increased training for custody officers to help identify these high risk dual-diagnosis detainees may be highly desirable.

A major prior study on women’s deaths in custody drew attention to gender-specific differences that prevail from a comparison of men and women’s deaths in police custody (Collins & Mouzos, 2002). In Australia, they found that the leading causes of death among women in police custody were natural causes, whereas for men it was suicide by hanging and multiple trauma injuries that were most frequently encountered. Collins and Mouzos also found that almost half of the women (and just over one-third of men) were in police custody as a result of an arrest for a public order offence (2002, p. 3). The present research found that only two of the women who died in police custody in Ontario were arrested for public order offences (Cases 1 and 5). Four of the women were arrested for violent offences (Cases 3, 4, 6 and 9). The remaining four women had been arrested for property (Cases 7 and 8) or drug offences (Cases 2 and 10).

Unfortunately, the coroner’s file gave no indication of the ethnicity of the women who died in police custody. The Australian research paid particular attention to the problems presented by significant numbers of Aboriginal women dying in police cells, often after having been arrested for public order offences (Collins & Mouzos, 2002). The present research found the women who died in police custody did so after being arrested for a wide variety of offences. Some were arrested following allegations of violence (“person-related” offense) (Cases 3, 4 and 9), one for a car theft (“property-related” offense) (Case 7), one for shoplifting (“property-related” offense) (Case 8), one on an outstanding warrant for assault (“person-related” offense) (Case 6), and two for drug offences (“drug – related” offense) (Cases 2 and 10). Only Cases 1 and 5 appear to have involved arrests for public intoxication (“public order” offense). Collins and Mouzos (2002) called for alternative strategies to imprisoning individuals for public order disturbances. This is clearly a good objective and ought to be considered here in Canada as well; however, for those who are brought into police custody, enhanced screening for medical distress and vigilance in the observation of detained persons are matters in need of ongoing attention.

The absence of data on ethnicity constitutes a limitation in this study. A further limitation arises from the small sample size. This issue appears to transcend most of the work in this area. This limitation could be remedied in the future if data is made available on a national scale. This would have the added benefit of enhancing the generalizability of the results.

## **Conclusion**

Women in police custody are more likely to die prematurely than those at large in the general population. While the causes of death are varied, a significant number of deaths continue to occur in police cells. This calls for attention to the detention regime in order to minimize the loss of life in that context. The minimal use of incarceration through decriminalization of minor public order offences, and the adoption of civilian-operated sobering centers as an alternative to the traditional police-operated “drunk tank” are obvious starting points.<sup>5</sup> Many police agencies have modified their cell design and imposed restrictions on items being brought into cells that could be used as a potential ligature device (Krames & Flett, 2005). This is often accompanied by increased monitoring, both by personnel assigned to the holding cells and through the use of closed-circuit television monitoring of cell areas. Each of these advances is to be commended and they have undoubtedly had a positive impact on limiting the numbers of deaths arising in police cells. The ongoing development and use of simple tests to estimate level of alcohol intoxication and suicide risk at the point of custodial intake may also have a desired preventive effect (Giles & Sandrin, 1992).

Training for police and custodial staff in dealing with individuals suffering from mental disorders is also an area of obvious concern. Many issues vie for attention in the curriculum of police training institutes. However, the likelihood is great that many police officers will spend a considerable amount of their time dealing with individuals suffering from mental disorders, as well as combined mental disorder and drug/alcohol problems. Accordingly, room must be made in the initial and ongoing training of officers to sensitize them to the needs of this group. Similarly, jail staff members require adequate training and vigilance in the supervision of detained individuals with special needs.

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<sup>5</sup> In the latter context, see the discussion and recommendations in Part 5 of the Davies Commission report (2009). The merit in providing sobering up facilities for both drug and alcohol dependant arrestees was recently noted by Hopkins and Sparrow (2006).

This chapter on women who died in police custody in Ontario reveals a need for alternative ways of addressing women in conflict with the law. Many of the women were held for non-violent offences, including some who were detained for petty crimes and public intoxication. Some of the women appear to have come from a marginalized background. The structural barriers some of them faced, including coping with mental health and addiction challenges, exposed them to considerable hardships that undoubtedly led them into interactions with the police. As a society, we need to find ways to enable these women to make their way through life without experiencing the trauma of incarceration where neglect and despair leads some to take their own life and others to succumb to a premature death from ill health.

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# **The Forum for Preventing Deaths in Custody: UK experiences with cross-sector cooperation**

Hannah Slarks & John Wadham

## **Introduction**

... the issues surrounding deaths in custody are similar, regardless of whether they are being faced by our prisons, our hospitals, our police stations or our inquiry bodies. This applies to healthcare, physical or mental, risk assessment and management, dealing with violent behaviour, training staff, or devising satisfactory procedures for inquests. (UK House of Commons, Parliamentary Joint Committee on Human Rights, 2004, p. 106)

The Forum for Preventing Deaths in Custody was established in the UK in 2005. It was created in response to growing calls for an organisation that could ensure that lessons were learned following custodial deaths and that these lessons were shared across all relevant agencies and institutions. These calls were based on increasing recognition that deaths in custody were a significant national problem (UK House of Commons, 2004, p. 107). They were also founded on an understanding that this problem could not be solved unless different agencies dealing with custody worked together to exchange experiences and ideas. Progress in individual sectors had shown that it was possible to reduce custodial deaths, but it was widely believed that cooperation was needed to capitalise on this progress and extend it further (Fulton, 2007, para. 14). The rationale behind a body capturing cross-sector learning was articulated in the Government's 2007 review of the Forum's performance:

- A death in custody is a uniquely serious and irremediable event.
- There is a special duty of care towards those in custody.
- The factors involved are many, complex and difficult.
- Many of these cut across the boundaries of individual services.
- Action within individual services, while essential, is therefore not sufficient.

- Deaths could be prevented (and the human rights of those concerned better protected) if there were more effective ways of learning lessons across sectors, and if decision makers at all levels were more effectively engaged. (Fulton, 2007, para. 13).

As far as we know, the Forum was an international first. Never before had there been a body designed to prevent deaths in custody across institutions (Forum for Preventing Deaths in Custody, 2007, p. 5). The Forum existed for only eighteen months before it was replaced by an altered successor organisation. In its short lifetime, many felt that it began to demonstrate the potential of cross-sector cooperation to prevent custodial deaths. However, it also started to reveal limitations on the cross-sector project, demonstrating the different approaches required within different sectors. Unfortunately, it was also limited by a dearth of resources and powers. Its successor, from its inception, has faced criticism that it will not constitute a significant improvement on the Forum (INQUEST, 2009).

This chapter will consider what the experience of the Forum can contribute to the wider debate on how to address custodial deaths. It will outline its history and consider what lessons can be learned from this institutional experiment. Finally, it will examine its successor body and proposals for creating an alternative institution.

## **History of the Forum**

### *Establishing the Forum*

The Forum was created as a response to demands for a body to oversee and monitor deaths in custody (Forum for Preventing Deaths in Custody, 2007, pp. 10-11). The central advocate of the proposals was the charitable organisation, INQUEST<sup>1</sup> (Forum for Preventing Deaths in Custody, 2007, pp. 10-11). In March 2003, momentum developed with the publication of Liberty's report<sup>2</sup>, 'Deaths in Custody: Redress and Remedies' (Vogt & Wadham, 2003), produced in collaboration with others, including INQUEST. A central recommendation of this report was the creation of:

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<sup>1</sup> INQUEST is a charity that provides a free advice service to bereaved people on contentious deaths and their investigation with a particular focus on deaths in custody. Casework also informs their research, parliamentary, campaigning and policy work. More information can be found at <http://inquest.gn.apc.org/>

<sup>2</sup> Liberty is also known as the National Council for Civil Liberties. It is a non-party membership organisation seeking to promote fundamental rights and freedoms in England and Wales. [www.liberty-human-rights.org.uk/about/index.shtml](http://www.liberty-human-rights.org.uk/about/index.shtml)

A separate, over-arching Standing Commission on Custody Deaths. Its mandate should be to bring together the experiences from the separate investigatory bodies set up to deal with police, prison, hospital deaths and others. Such an overarching body could identify key issues and problems, develop common programmes, research and disseminate findings where appropriate, and ensure services work together for change. Lessons learned in one institution could be promoted in other institutions, best practice could be promoted, and new policies designed to prevent deaths could be drafted and implemented across all institutions. Differing policies could be identified and changes suggested (for example with regard to restraint techniques, where it appears that every institution has different policies) (Vogt & Wadham, 2003, p. 66).

Four months later, the Joint Committee on Human Rights (JCHR), made up of Members of the Houses of Commons and Lords, launched a major inquiry into deaths in custody. Evidence was contributed by many of the organisations that would become members of the Forum. A consensus was emerging, as these groups advocated the creation of a Forum or Standing Commission (Forum for Preventing Deaths in Custody, 2007, pp. 10-11; Crossman, 2003, p. 21; INQUEST, 2003, p. 4). In its submission, INQUEST reiterated and expanded on the proposals in Liberty's report. It argued:

... an over-arching body could identify key issues and problems arising out of the investigation and inquest process following deaths and it would monitor the outcomes and progress of any recommendations... It would play a key role in the promotion of the culture of human rights in regard to the protection of people in custody. It should also have the power to hold a wider inquiry where it sees a consistent pattern of deaths (INQUEST, 2003, p. 4).

The JCHR published its report in 2004. In a central recommendation, it called upon the Home Office and Department of Health to establish a cross Government expert task force on deaths in custody (JCHR, 2004). Specifically, it stressed that the body should be an 'active, interventionist body, not a talking shop'; that the membership should be drawn from people with 'practical working experience of the problems associated with deaths in custody'; and that the body should have at its disposal human rights expertise (UK House of Commons, 2004, p. 107; Fulton, 2007, para. 6). It made a number of recommendations for specific powers and functions of the body:

- To share information on good practice in preventing deaths in custody between each form of detention;
- To develop guidelines on matters relating to prevention of deaths in custody;
- To review systems for the investigation of deaths in custody and to seek to establish consistency in such investigations;
- To develop consistent good practice standards on training in issues relating to deaths in custody;
- To review recommendations from coroners, public inquiries and research studies, to consider how they can be taken forward, and to monitor progress in their implementation;
- To collect and publish information on deaths in custody;
- To commission research and to make recommendations to Government. Where such recommendations involve expenditure we would expect the Government to meet the needs where funding was clearly necessary to ensure observance of ECHR rights. (UK House of Commons, 2004, p. 107).

In response, the Independent Police Complaints Commission (IPCC) suggested the creation of a forum to capture cross sector learning following deaths in custody (Forum for Preventing Deaths in Custody, 2007, pp. 10-11). The proposal was well-received by custodians and investigators of deaths in custody (Forum for Preventing Deaths in Custody, 2007, pp. 10-11).

Within the next year, a series of meetings brought together key organisations such as the Prisons and Probation Ombudsman’s Office and HM Inspectorate of Prisons. A consensus quickly emerged on the benefits of agencies sharing information and learning across institutions (Forum for Preventing Deaths in Custody, 2007, pp. 10-11). A year after its publication, the Government responded to the JCHR’s report by committing to work with key agencies to establish a new multi-agency forum. The Forum met for the first time in November 2005.

### **The Forum’s remit**

In some ways, the Forum’s remit reflected the long-standing proposals for a Standing Commission on deaths in custody. The heart of its work was to be sharing information and learning (Forum’s website, “Sharing Information”). It was tasked with promoting best practice across sectors, facilitating joint discussion and disseminating existing written work (Forum’s website, “Sharing Information”). In response to the JCHR warnings about the creation of a “talking shop”, the Forum’s Terms of Reference stated, “the

Forum exists to affect real change to prevent deaths in custody” (Forum for Preventing Deaths in Custody, 2007, p. 10).

The Forum was to work on issues falling within the remit of its sponsoring Departments: the Home Office, the Ministry of Justice and the Department of Health. This would include deaths of people detained in police custody, prison, approved premises, immigration custody or those detained under the Mental Health Act. Deaths occurring after prison release and ‘near deaths’ were also to be incorporated into the Forum’s scope. These were acknowledged as important sources of learning. The purpose of the Forum was not to investigate individual deaths. Member organisations were already responsible for investigations within their own fields. Instead, it was to look at trends and themes in deaths in custody.

However, in a number of important respects, the Forum’s remit fell short of that suggested by INQUEST, Liberty and the JCHR’s proposals for a Standing Commission. The Forum had no formal powers. It was designed to affect change only through its credibility among practitioners and government. It had no statutory basis (Forum’s website, “How the Forum Works”) and no remit to monitor compliance with its recommendations. It had no power to undertake a statutory inquiry. Even within the remit it had been given, the Forum would not be sufficiently resourced to deliver much of the work envisaged by advocates of a Standing Commission. Crucially, it had no budget for major cross-sector research.

### **The Forum’s structure**

The Forum was chaired by John Wadham, former Deputy Chair of the IPCC, now the Legal Director of the Equality and Human Rights Commission, and a co-author of this chapter. At its formation, the Forum included 14 organisations from Government, police, healthcare, prisons, coroners and the independent sector. These organisations were:

- Independent Police Complaints Commission (IPCC)
- Association of Chief Police Officers (ACPO)
- Coroners’ Society
- Department of Health, which sent representatives from:
  1. High Secure Services
  2. Offender Health
  3. National Offender Management Service
  4. National Patient Safety Agency
- Prisons and Probation Ombudsman (PPO)
- Her Majesty’s Inspectorate of Constabulary (HMIC)
- Policing Powers and Protection Unit, Home Office

- Her Majesty's Inspectorate of Prisons (HMIP)
- Mental Health Act Commission (MHAC)
- National Offender Management Service (NOMS)
- National Probation Directorate
- Prison Service (PS)
- Youth Justice Board (YJB)
- INQUEST
- Her Majesty's Revenue and Customs (HMRC)
- United Kingdom Border Agency (UKBA)

However, the Forum's membership was open-ended. It grew to more than 30 members and was still growing 18 months after its establishment (Fulton, 2007, para. 17).

The Forum met three times a year to discuss an agenda that it set for itself. Between these meetings, preparatory work was undertaken by smaller working groups (Forum's website, "How the Forum Works"). The Working Groups involved both Forum member organisations and non-member organisations with expertise relevant to their particular subject-matter. In this way, the Working Group structure also facilitated engagement with practitioners (Forum's Website, "How the Forum Works"). Three Working Groups were established during the Forum's existence. These looked at the physical custody environment, family liaison and cross-sector learning.

In order to ensure that the Forum's work fed into government, the Forum developed links with the Ministerial Roundtable on Suicides in Prisons, which was chaired by the Justice Minister. Informal discussions took place between members of the Forum and the Ministerial Roundtable, leading to plans for the two bodies to work collaboratively and integrate their approaches. Although the Forum came to consider the roundtable its 'sister organisation' (Forum for Preventing Deaths in Custody, 2008a, p. 13), their relationship was never formalised. Since the scope of the Roundtable was far more limited than that of the Forum, the ability of the two organisations to function in collaboration was necessarily restricted.

### **The Forum's activities**

The Forum's ongoing work consisted of group discussion and dissemination of written material. In a police context, this involved disseminating the 'Learning the Lessons Bulletin', a bi-monthly inter-agency publication on lesson-learning with the police service. Discussions at meetings explored how member organisations learned from deaths and shared information. They examined how recommendations from inspections, investigations and

inquests were handled. Each meeting generally focused on one main theme. At one meeting, the Forum considered how prisoners and detainees were managed. Another explored how staff members were trained to prevent deaths in different custody environments. Another examined issues relating to women in custody, and was informed by the recent publication of the government-commissioned ‘Corston Report: A Review of Women with Particular Vulnerabilities in the Criminal Justice System’ (Corston, 2007).

The publication of the Forum’s Annual Reports focused public attention. The reports brought together cross-sector statistics on deaths in custody for the first time. These figures were widely reported in the media.

The Forum conducted discrete projects in addition to its ongoing activities. These were described by the independent reviewer of its work as “useful achievements” (Fulton, 2007, para. 11). A key achievement was influencing ministers to improve the handling of recommendations produced by coroners (known as Rule 43 letters). Under these improvements, coroners’ recommendations will now be stored centrally, in an accessible form; relevant agencies will be required to respond and make improvements; and coroners will have the power to enquire into the nature of these responses (Forum, 2008b).

Another important achievement was the publication of several thematic reports. In 2009, the Forum produced a piece of research exploring investigations into deaths in custody, and whether these investigations complied with Article 2 of the European Convention on Human Rights (ECHR) in all the scenarios where deaths can take place<sup>3</sup> (Forum for Preventing Deaths in Custody, 2008a, p. 12; Barty, 2009). It revealed patchy compliance with Article 2 across the sectors, raising particular concerns about deaths in secure children’s homes and deaths of detained mentally-ill patients. The ‘Report of the Working Group on Managing Physical Custody Environments to Reduce Suicide and Self Harm’ produced the first cross-sector analysis of safe custody environments. It facilitated information-sharing and comparisons of custody environments in different institutions, shedding light on both best practice and gaps in provision (Working Group on Managing Physical Custody Environments to Reduce Suicide and Self Harm, 2007).

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<sup>3</sup> Article 2 of the ECHR deals with the right to life. In a number of landmark European and UK cases, this has been held to require the State to investigate deaths in custody fully. E.g. *Aydin v Turkey* 1997 25 EHRR 251; *Jordan v UK* 2001 38 EHRR 52; *R (Amin) v Secretary of State for the Home Department* [2003] UKHL 51.

## **The dissolution of the Forum**

In May 2007, 18 months after the Forum was established, the Government committed to reviewing its structure. It asked a former Home Office Director, Mr. Robert Fulton, to conduct an independent review of its arrangements and report to Parliament within 6 months (Forum's Website, "Forum's Background").

The Fulton Report examined the Forum in conjunction with the Ministerial Roundtable on Suicide in Prisons, in order to assess how its work fed into Government and consider models for a more effective set of machinery for preventing deaths in custody (Fulton, 2007). Mr. Fulton concluded that the Forum and Ministerial Roundtable on suicide should be replaced by a three-tier structure, consisting of a Ministerial Board, a small Independent Advisory panel and an open-ended stakeholder group. All three parts of the structure would be served by the same secretariat. The report did not recommend the provision of new statutory powers (Fulton, 2007, p. 35). Finally, it recommended that there should be a further review in 2010, to assess whether the new structures had been instrumental in reducing the number and rate of deaths in custody (Fulton, 2007, p. 14).

Fulton's proposal was accepted by the Government. It was announced that the Forum would be wound-down and replaced by the proposed tripartite structure, collectively entitled 'The Ministerial Council on Deaths in Custody' (Eagle, 2008). Hope was expressed that this new structure would provide more direct links with Ministers, as the 'ultimate decision-makers' (Eagle, 2008). At the time of writing this essay, in 2009, the Forum had been dissolved. Members of the new structures had been appointed and a basic work plan had been announced. Work had commenced, but very little had been made public. Even now, it remains to be seen whether the Ministerial Council will successfully improve upon the Forum. The final sections of this Chapter will explore the future of the Ministerial Council and its potential successors in more detail.

## **What lessons can be learned from the Forum?**

### **Benefits of cross-sector cooperation to ensure lessons are learned**

The Forum's most distinctive feature as a preventative mechanism was its emphasis on cross-sector cooperation. Its work demonstrated a number of benefits of this method.

Within the Forum, specific lessons from one sector could be transferred to other sectors. The 'Working Group on Managing Physical Custody Environments to Reduce Suicide and Self-harm' provided an excellent example of this effect (Fulton, 2007, para 11). Its report (11 June 2007),



constituted a comparative study of the approaches taken across custodial sectors to achieve the safest possible physical environment. It highlighted best practice, including the Prison Service's "Safer Cell" development scheme. In particular, it discussed an in-house bespoke range of low cost, anti-ligature furniture developed by the Prison Service (Working Group on Managing Physical Custody Environments to Reduce Suicide and Self Harm, 2007, p. 2). The report recommended the creation of a directory of effective and affordable products and materials used by custody sectors. Such a directory could have a significant practical impact in other sectors.

Discussion at meetings highlighted other opportunities for transfer of best practice. For example, despite a history of restraint related deaths, the UK Prison Service has experienced a substantial drop in the number of restraint related deaths over the last decade. Meanwhile, other custodial sectors continue to grapple with this problem. It was felt by many that future cooperation might transfer to other sectors the positive restraint practices developed by the Prison Service (Forum for Preventing Deaths in Custody, 2007, p. 14). In another example, when the Independent Police Complaints Commission began to publish a "Learning the Lessons Bulletin" produced by a multi-agency panel of police stakeholders, the Forum was able to promote the project (Forum for Preventing Deaths in Custody, 2008a, p. 6). The Forum not only disseminated Bulletins within other sectors, but encouraged and facilitated the creation of a similar publication by the prison sector, now entitled "Learning Lessons Bulletin" (Forum for Preventing Deaths in Custody, 2008a).

It was able not only to share best practice, but also to flag up problem areas and lessons learned from deaths (and near deaths) within different sectors. In the above report on physical custody environments, the police sector highlighted its finding that many deaths in the police custody were caused by ligature points that developed when cells were not repaired regularly (Working Group on Managing Physical Custody Environments to Reduce Suicide and Self Harm, 2007, p. 23). This warning could prevent deaths in other sectors. It also paved the way for future work when the Working Group recommended closer cross-sector liaison on maintenance contractors sensitive to these issues.

As well as transferring specific lessons, the Forum was uniquely placed to identify cross-sector trends. Its first Annual Report was the first public document to include statistics on all custodial deaths across the sectors, amounting to approximately 600 each year in the UK (Forum for Preventing Deaths in Custody, 2008a, p. 7). The report also identified the cross-sector problem of failure to treat alcoholism with sufficient seriousness (Forum for Preventing Deaths in Custody, 2008a, p. 15).

The process of identifying trends helped cast light on issues within specific sectors. For example, the Forum conducted a piece of research on the quality of investigations into deaths, examining their compliance with the European Convention on Human Rights Article 2 obligations. The comparative work drew attention to two sectors that appeared to have fallen behind the rest: Investigation procedures into deaths of detained patients and deaths of children in Secure Children's Homes (Forum for Preventing Deaths in Custody, 2008a, p. 17; Barty, 2009, pp. 22-23). It also carried out a similar study of investigations into near-deaths. This found that Article 2 compliance was variable across the sectors, with particular improvements required in relation to the processes of the Independent Police Complaints Commission. Having viewed their own performance in this wider context, the IPCC then put in place processes to remedy this discrepancy.

Cross-sector cooperation also gave the Forum the opportunity to examine the custodial experience as a whole, including detainees' and prisoners' experience of interaction between agencies. It was able to explore the ways in which these interactions contribute to custodial deaths. Much discussion explored the use of the Prisoner Escort Form, which is used to record information about people in custody, and is often the only method of transferring information about risks from one agency to the next (Forum for Preventing Deaths in Custody, 2007, pp. 8-9). The Forum highlighted the need to develop the Form to reflect the needs of both the prison and police service (Forum for Preventing Deaths in Custody, 2007). Its work also prompted further consultation between the Police and Prison Services on ensuring that the Police Computer Network is available to prison staff to both access and input data (Forum for Preventing Deaths in Custody, 2007, p. 9). It argued that this would improve safety when either agency deals with an individual who has already been dealt with by the other. Given the frequency with which vulnerable individuals interact with multiple custodial agencies, a shared computer network could save lives. The same piece of work also explored the placement of people in unsuitable custodial environments (Forum for Preventing Deaths in Custody, 2007, p. 15). This common phenomenon sees both mentally and physically ill people housed in conditions that cannot meet their needs. Inter-agency cooperation could help identify how misplacement occurs and how systems can be improved to ensure that misplaced people are efficiently transferred to the appropriate environment.

Finally, cross-sector cooperation facilitated the coordination of policy work and lobbying government. As noted above, the Fulton Report praised the Forum for its work influencing ministers to improve the handling of recommendations produced by coroners (known as Rule 43 letters) (Fulton,

2007, para. 11). This development followed a letter from the Chair of the Forum to the Minister of State for Constitutional Affairs and a subsequent meeting (Forum for Preventing Deaths in Custody, 2007, p. 20). The Forum also wrote to Ministers and Chairs of parliamentary committees to oppose government proposals to introduce secret inquests in the Draft Counter Terrorism Bill (Forum for Preventing Deaths in Custody, 2008a, p. 10). This was followed by meetings with senior civil servants (Forum for Preventing Deaths in Custody, 2008a). Further, the Chair wrote to Ministers regarding the means-testing of legal aid given to bereaved families at inquests relating to custodial deaths (Forum for Preventing Deaths in Custody, 2008a, p. 11). By presenting a united position, the expert voices in the Forum could be coordinated into one more powerful and persuasive voice. However, the success of this coordination was naturally restricted by the Forum's limited resources and powers.

### **Inherent problems with cross-sector cooperation**

The Forum was an experiment in cross-sector working as a method of prevention. Although it revealed many benefits, it also indicated the limitations on cross-sector comparison. Discussion often highlighted the very different challenges facing different sectors. For example, the Prison Service has managed to substantially decrease restraint-related deaths. However, the methods it used and the achievements it has made could not be easily transferred to the Police Service. The police constantly confront dangerous situations in the uncontrolled street environment where members of the public are at risk. Lessons from the regulated environment of prison custody can only have so much benefit in the policing context. Similarly, other Forum members highlighted the importance of distinguishing between coping with prisoners and patients. Although many custodial service-providers deal with mentally ill people, the rights of detained patients are clearly distinct. Often, methods used to deal with prisoners would not be appropriate as part of patient care.

Attempts at cooperation through the Forum highlighted these differences as much as they identified trends. For some they raised questions about the validity of the entire project. They suggest that the focus of efforts to eliminate custodial deaths should instead come from within the individual sectors. However, since resource and powers constraints hamstrung the Forum's capacity to achieve practical results, it had little chance of disproving this hypothesis.

### **The need for strong institutional structures**

As we have begun to suggest, the Forum was hampered by a number of institutional weaknesses that provide valuable lessons for the future.

First, the Forum's structure was not conducive to feeding its expertise and findings directly into government. Only informal links were established with the Ministerial Roundtable on Suicide in Prisons. The Forum therefore had no power to ensure its recommendations were considered seriously (Forum for Preventing Deaths in Custody, 2007, p. 24). Further, the remit of the Ministerial Roundtable was much narrower than that of the Forum, giving it little incentive to consider the Forum's findings where they did not relate explicitly to suicide in prisons. The Fulton report stressed that significant Ministerial involvement is vital to ensure "accountability and the authority to commit to action" (Fulton, 2007, para. 9). The Joint Committee on Human Rights observed that the Forum was regularly cited in government sources (Fulton, 2007, para. 7). However, the Committee was also 'not persuaded' that this was sufficient for it to play the interventionist role it had envisaged in the JCHR's 2004 report (cited in Fulton, 2007, p. 7).

Second, the Forum was significantly under-resourced. This meant that it was unable to commission research into the majority of the issues that it identified as requiring further analysis (Forum for Preventing Deaths in Custody, 2007, p. 6). Where it could undertake research, a lack of resources limited that research in depth and scope (Forum for Preventing Deaths in Custody, 2008a, p. 14; Coles & Shaw, 2008, p. 30). It was also difficult to produce research quickly, since work relied on the generosity of members with their time and the capacity of its over-burdened secretary (Forum for Preventing Deaths in Custody, 2008a, p. 12). The Fulton report noted that since there was no capacity for systematic information gathering, the balance of information held by the Forum was skewed towards those sectors that voluntarily provided the most information themselves (2007, para. 10). It also had no ability to monitor responses to its recommendations (Forum for Preventing Deaths in Custody, 2007, p. 24). Neither did it have sufficient resources to monitor whether and how Coroners' recommendations are implemented (Forum for Preventing Deaths in Custody, 2007, p. 24). These limitations seriously undermined the extent to which it could function as a useful body. Without the capacity to routinely collate and analyse data on deaths in custody (Coles & Shaw, 2008, p. 30), it could only identify patterns through the anecdotal experience of its members. Once patterns were identified, it was almost impossible to respond quickly and meaningfully to them. Given these constraints, it is perhaps unsurprising that some members of the Forum did not see it as "very relevant to their concerns" (Fulton, 2007, para. 10).

These problems could have been partially remedied by a significantly increased budget. However, the Fulton Report also discussed the value of effective human resources, in the form an active secretariat, "with the capacity to drive action, think and influence" (2007, p. 31). This kind of

secretariat would need to be qualified and enabled to routinely monitor statistics, coroners' reports and responses to recommendations. In this way, issues could be identified more quickly and effectively. A useful secretariat should also have the capacity and expertise to maintain an "up to date and informative website for practitioners and other interested parties, and issue e-bulletins to update them on new development and lessons learned" (Fulton, 2007, p. 320). This would ensure that the information-sharing was a continuous process, ongoing between specific projects and meetings.

Third, the Forum did not have any inherent or statutory powers (Forum for Preventing Deaths in Custody, 2007, p. 24). Its powers were based entirely on its ability to persuade decision-makers. This problem could have been somewhat remedied by increasing links to government (see below analysis of the Ministerial Council). However, this would have been unlikely to provide a complete solution. Custodial deaths, by their nature, will always be difficult ground for government. It will often be in governments' political interest to ensure this issue keeps a low profile. If they act preventatively, they are open to criticism for devoting too many resources to the comfort of criminals. If they act mistakenly or belatedly, they risk accusations of responsibility for deaths of those in the care of the State. For this reason, a successor to the Forum would benefit from statutory, independent powers of inquiry, recommendation and monitoring, allowing it to ensure lessons are learned, even when those lessons might embarrass the government.

Fourth, the Fulton report highlighted structural weaknesses relating to the membership of the forum (Fulton, 2007, para. 10). It argued that the Forum's membership was "too large and diverse to be effective as a decision-making and executive body" (Fulton, 2007). Further, the nature of the membership was seen as problematic. Mr. Fulton argued that since service members attended as representatives of their organisations, they were restricted from endorsing "conclusions which run counter to existing policy or have difficult cost or operational consequences" (Fulton, 2007, para. 10). He suggested that this was an obstacle to openness and lesson-learning (Fulton, 2007).

These kinds of difficulty are inherent to a body that attempts to coordinate policy across broad sectors. The Forum did include a large spectrum of operational custody providers, oversight bodies and NGOs. However, there were also benefits to the Forum's membership structure. Although the group was large, it allowed all relevant organisations to be fully involved, facilitating an equal exchange of their different perspectives and experience. Since the establishment of the Ministerial Council, INQUEST has expressed concern about streamlining its membership by separating it into

three groups: Ministers and service providers; independent experts; and a wider group of stakeholders (INQUEST, 2009, p. 3). They argue that this may constrain the flow of information and leave stakeholder organisations separated from decision-makers. The effect of organisational affiliations can also be viewed in a positive light. Although organisational representatives were sometimes constrained by their organisations' positions, they also brought valuable connections to the institutions with the ability to implement new ideas. Establishing policy consensus might be slower when one is seeking the commitment of budget-constrained organisations, but once established it can be more powerful. Once properly engaged with an idea, those organisations can then implement it directly. Conversely, a group of independent experts may be able to agree on issues efficiently, but will then still have to persuade the organisations with the power to make changes. This process of inclusive consensus-building was particularly important for the Forum, since its powers were based entirely on persuasion.

### **The future of cross-sector cooperation for the prevention of deaths in custody in the UK: Have the lessons of the Forum been learned?**

#### **The Ministerial Council**

The basic structure of the Ministerial Council was mentioned above. However, in order to consider whether lessons have truly been learned from the experience of the Forum, it is necessary to take a closer look at the Council.

The Fulton Report (2007, para. 15) identified five general characteristics of a successful model for cross-sector prevention of deaths in custody. It argued that the body charged with preventing deaths in custody should be:

- **A**  
**uthoritative:** The key decision-makers (i.e. ministers and service heads) should be engaged.
- **E**  
**ffective:** Real action should result which reduces the incidence of death in custody.
- **E**  
**xpert:** Decisions at all levels should be informed by the best available expert advice, based on reliable evidence.
- **I**  
**ndependent:** There should be a capacity for recommendations to be made which would involve changes to existing government policy or which might have difficult financial or operational

consequences, if considered desirable in the interests of preventing deaths in custody.

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**R**

**representative:** Everyone with an interest in preventing deaths in custody should have the opportunity to contribute.

The structure of the Ministerial Council, designed in the Fulton Report, is intended to give the Council these characteristics. The Fulton Report explained the structure roughly as follows:

- The Forum on Preventing Deaths in Custody should be replaced by an Independent Advisory Panel on Deaths in Custody. This should be a small group, selected for relevant expertise, and its members should not be representatives of government departments or operational services.
- The Independent Advisory Panel should be supported by a Stakeholder and Practitioner Group, whose membership would include many of the members of the existing Forum. This would be an open-ended and potentially large group, comparable to the existing Forum. However, most of its work would be done in standing or ad-hoc working groups. Plenary meetings might best be held in the context of an annual deaths in custody conference, to which members of the Ministerial Board and other interested parties (e.g. bereaved families and staff with first-hand experience of deaths in custody) could also be invited. The Panel would be expected to take account of the views of the Practitioner and Stakeholder Group, and to ensure, through the participation of the members of the Group, that its deliberations were grounded in practical reality. But the ultimate responsibility for recommendations and guidance would rest with the Panel, who would be free to report as they saw fit even if this did not have the unanimous support of the Group.
- The Ministerial Roundtable on Suicide in Prisons should be replaced by a Ministerial Board on Deaths in Custody, with senior representation from all the organisations which hold people in custody or which are otherwise concerned with the issue. It should be the key means of ensuring that the issue of deaths in custody is kept prominently in the minds of ministers and service leaders. The Board should be chaired by the lead minister at the Ministry of Justice, with Home Office (police) and Department of Health (secure services) ministers as co-chairs.
- All three organisations should be serviced by the same secretariat, strengthening the links between them. The secretariat should have

a staff and budget which will enable it to act as an effective central point for learning and communication about means of preventing deaths in custody.

Given the diverse characteristics Mr. Fulton outlined, the Ministerial Council may provide an innovative structure for cross-sector learning. At the top, the Ministerial Board could ensure the Council is authoritative and effective. The Advisory Panel and Stakeholders group could help it to be expert, independent and representative. Splitting expert involvement into a slimmed-down, active Advisory Panel and a wider Stakeholders group has the potential to harness broad expert input, without jeopardising the efficiency provided by a small, active Panel. Ensuring representatives of the Advisory Panel contribute as independent experts, rather than representatives of government and operational services, could facilitate a more open and constructive discussion (Fulton, 2007, para. 17). Aligning the remit of the three structures and combining the secretariats could help them achieve real collaboration, and in this way, drive forward real change.

However, remaining problems have been identified in the new Council. The Forum's final report stated categorically that the Council still "falls short of the kind of body envisaged by the Joint Committee on Human Rights, or of INQUEST's proposal for a Standing Commission on Deaths in Custody" (Forum for Preventing Deaths in Custody, 2008a, p. 1). The Forum's limited budget acted as a damaging constraint on its powers. The Council's budget will be enlarged, but concerns have been raised that it still lacks what would be needed to fund effective ongoing research, policy development, and monitoring (Forum for Preventing Deaths in Custody, 2008a). Many former Forum members believe there should be a significant dedicated research budget, allowing the Independent Advisory Panel to commission research as it sees fit, without having to request additional funding from central Government Departments for specific projects (Forum for Preventing Deaths in Custody, 2008a, p. 1 and p. 14). INQUEST believes the Council suffers from an even more fundamental flaw. It has pointed out in its 'Notes on the Fulton Report' that the Council, like the Forum, has no statutory remit or inherent powers (Forum for Preventing Deaths in Custody, 2008a). This may put it in a weak position to affect change. For this reason, INQUEST believes that the creation of the Council does not remedy the structural deficiencies that undermined the Forum.

### **Continuing calls for a Standing Commission**

Amid concerns about the capacity of the Ministerial Council, calls for a Standing Commission continue (INQUEST, 2011). To conclude this



analysis of the Forum, it may be useful to take a closer look at the proposals for a Standing Commission and consider how the experience of the Forum should affect our perspective on this much-mooted idea.

Although precise proposals vary, it is possible to form a general picture of a Standing Commission on Deaths in Custody. A Standing Commission would be “properly resourced, independent (and) overarching” (Coles & Shaw, 2008, p. 30). Such a body should be able to examine deaths in custody in their broader social and political context, considering the impact of criminal justice and social policies (Coles & Shaw, 2008, p. 30). The body would need statutory powers of wider inquiry where there is a consistent pattern of deaths (Crossman, 2003, p. 21). The existence of a Standing Commission would mean such patterns could be recognised early. This would trigger the prompt establishment of an inquiry, without protracted negotiations with central government over the need to investigate the matter further and the resourcing of any investigation (Crossman, 2003, p. 21). During the inquiry process, the Commission would have the power to insist on access to documents and to summon witnesses (Vogt & Wadham, 2003, p. 66). The inquiry would then produce recommendations, enforced by a well-resourced monitoring system. This kind of system could ensure lessons are learned more quickly and effectively, preventing future deaths.

In many ways, the formal power and independence of this body would mirror those of sector-specific investigatory bodies, such as the IPCC or the Prison and Probation Ombudsman. However, its role would be quite different (Vogt & Wadham, 2003, p. 66). It would investigate patterns of deaths rather than specific deaths. It would consider wider social policy issues contributing to the pattern, as well as the operational policies governing the custodial environment (Coles & Shaw, 2008, p. 30; Crossman, 2003, p. 21). Perhaps most importantly, it would consider deaths across custodial sectors. This would allow best practice to be shared efficiently. It should also facilitate greater understanding of the causes of those deaths that may seem unusual within a particular sector, but form part of a wider pattern when examined in a cross-sector context.

The proposed Standing Commission could also be used to reinforce and support existing investigatory systems. It is arguable that a Standing Commission should have the power to intervene in any inquest. This would allow the Commission’s cross-sector expertise to inform the investigation of specific cases, providing a valuable resource for coroners tackling the complex issues surrounding custodial deaths. The Commission could also form institutional links with sector-specific bodies, providing expert advice wherever it might cast light on a specific investigation and ensuring lessons

from novel cases are relayed across the sectors (Vogt & Wadham, 2003, p. 66).

The experience of the Forum has served to reinforce the value of many aspects of these proposals. The discussions and small pieces of research undertaken by the Forum demonstrated the value a cross-sector approach. At the same time, the Forum's inability to call particular witnesses, intervene in investigations and inquests, fund significant research projects or monitor its recommendations underlined the importance of powers and funding. Without these, a cross-sector body can only affect limited change and risks remaining a "talking shop", as the JCHR warned (UK House of Commons, 2004, p. 107). The Ministerial Council may have a slightly enlarged budget and more stream-lined structure, but will be unlikely to provide the full benefits of a Standing Commission.

## **Conclusions**

As an organisation, the Forum was limited by a lack of resources and powers. This is not a problem easily solved. In order to actually reduce the number of deaths in custody, a successor body would have to be significantly restructured and given far more resources. If the Forum taught us anything, it might be that to be the panacea people are hoping for, a cross-sector cooperation body would be expensive and politically controversial to establish. Given this conclusion, it is unsurprising that the new Ministerial Council is also under-resourced.

This chapter has attempted to assess the Forum not only as an organisation, but as an illustration of cross-sector cooperation as a concept. It was a test case. However, as we noted above, it provided a poor test. It is difficult to say whether a properly resourced institution would have vindicated or undermined the cross-sector project. As we have shown, its few practical achievements showed significant potential for the cross-sector project in terms of lobbying, practical work and information sharing. This said, it also highlighted the problems with very different sectors working together towards a common goal. Preventing deaths in custody will often require a very different approach in one sector than it will in another. Focusing efforts and resources on common strategies might risk overshadowing the need for specialist work within the separate sectors. If this is the case, the cross-sector concept itself may be flawed. At the very least, it could not truly prove its worth in the form of the Forum.

This leaves the way forward unclear. A pessimist might be tempted to abandon the cross-sector project altogether. Its inherent limitations will only be compounded by the political difficulties that are always likely to restrict resource allocation within this policy area.

Despite our criticisms of the Forum, we believe that this approach would mean valuable opportunities for preventing deaths were missed. Much of the work undertaken and proposed by the Forum could only be done successfully by strong cross-sector working. The question is how this can be best achieved.

A number of different models might be tried in the UK or elsewhere to put lessons taught by the Forum into practice. One model could deepen coordination even further. In the UK, there are independent bodies dealing with custodial deaths in each sector. Conceivably, these might be merged into one body incorporating different strands. A similar merger was effected with some success when the UK bodies dealing with Disability, Race and Gender Discrimination were merged into the Equality and Human Rights Commission. This model might appeal to those truly committed to cross-sector working. It would allow close coordination. It would also harness the resources and powers already established within sectors as part of a common effort.

However, this model seems unlikely to be applicable in the context of deaths in custody. The organisations overseeing each sector have many functions and areas of concern other than preventing deaths. Although some of these other functions might also benefit from cross-sector coordination, many would do not lend themselves to existing within the same organisation. For example, the Care Quality Commission is responsible for preventing deaths of detained mentally ill patients, but more broadly it is the independent regulator of health and social care across the country. The CQC's other functions clearly have very little to recommend a merger with, for example, the Prison and Probations Ombudsman. Its remit includes both mentally ill and physically ill patients partly in order to place the emphasis on patient care when setting standards for treating mentally ill people. This kind of emphasis might be lost in a cross-sector organisation dealing primarily with detainees and prisoners. Equally, it would seem very unwise to reassign those functions that did relate to deaths in custody from sector-specific bodies to a cross-sector body: Within any one sector, effective prevention of deaths cannot be undertaken in an isolated policy bubble. It must be mainstreamed within the sector's approach to service delivery. Accordingly, a cross-sector body preventing custodial deaths could never replace the important work done within the sectors.

We may be left with the answer that we began with: A Standing Commission with formal powers to conduct research and inquiries, and facilitate shared working between the sectors. The Forum has shown that for such a body to work, many political hurdles will have to be cleared to ensure it is

properly resourced. It will also be a difficult task to find a structure that is both inclusive and effective. However, the Ministerial Council may offer a clearer solution to that problem. In light of the Forum's history, we might venture one added nuance to the proposals for a Standing Commission. It must be stressed that cross-sector cooperation cannot be expected to mop up work that should be done within specific sectors. Preventing deaths must be integrated into the everyday work of improving standards in custody and care. Cross-sector cooperation is necessary to ensure useful information is properly shared and the custody process is seamless between agencies. However, it will not be able to replace proper investigation, research and practical work within each sector. Improvement must continue in these areas. Cross-sector work is not the silver bullet, but should be part of our collective armoury.

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# Police Complaints in the United Kingdom

Dr. Dominic Wood

## **Introduction: The three systems of police complaints in the UK**

The main purpose of this chapter is to outline how complaints against the police are administered and organised in the United Kingdom (UK). The first part of the chapter will examine the evolution of police complaints systems within the UK and outline the structures that are currently operational in England and Wales, Scotland and Northern Ireland. The second part of the chapter will consider how commonly identified and enduring features of police complaints systems globally have been addressed within these three UK contexts. There are, however, two preliminary points that need to be stated at the outset that provide further parameters of the chapter.

The first preliminary point to note is that serious attention only began to be applied to police complaints systems in the UK in the second half of the twentieth century. As Marshall (1978) notes, surprisingly little attention had been paid to police complaints in the UK prior to the 1950s. This is despite the fact that the UK has a relatively rich history of ‘modern’ policing dating back at least to the 1829 Metropolitan Police Act (Reiner 2000). However, notwithstanding Goldsmith’s (1995, p.117) reference to complaints against the police being a prominent feature in royal commissions in the UK in 1908 and 1929, it is not until the royal commission in 1962 that this matter was addressed in a substantive manner. However, by the late 1950s dealing with complaints against the police had become, as Seneviratne (2004, p.329) notes, very much a “live issue”. This became increasingly the case towards the end of the twentieth century and the issue of police complaints has continued to be a hot topic in the first decade of the twenty-first century.

The second point that needs to be made at the outset is that there are three quite distinct models of police complaints systems operating in the UK. In England and Wales complaints are dealt with by the Independent Police Complaints Commission (IPCC), which was established following the Police Reform Act 2002 and became operational in April 2004. In Scotland, the Police Complaints Commissioner for Scotland (PCCS) was introduced in 2007 following the Police, Public Order and Criminal Justice (Scotland)



Act 2006 and in Northern Ireland complaints are dealt with by the Office of the Police Ombudsman for Northern Ireland (PONI), which became operational in November 2000, two years after to being 'provided for' within the Police (Northern Ireland) Act 1998 (Mulcahy 2006, p.176). The PONI has been an important aspect of the ongoing peace process in Northern Ireland after being identified as a necessity following a report into the police complaints system in Northern Ireland (Hayes 1997) and the publication of Patten's (1999) review of policing arrangements in the province.

Before looking at each organisation in more detail it is necessary to give some context to explain why there are three distinct police complaints systems in the UK.

### **Policing in the UK**

Discussions about policing in the UK commonly refer more precisely to policing arrangements in England and Wales, understood here as a single political entity. England and Wales are separate countries and following the Government of Wales Act 1998, Wales has had its own devolved government, the Welsh Assembly. However, in relation to many aspects of governance in the UK, beyond but also including policing, England and Wales constitutes a single, constitutional and legal entity. Historically, this is a consequence of the fact that Wales was subsumed within the Kingdom of England long before the 'union' state came together to form what is now the UK (Walker 2000). Consequently, in relation to matters of police governance, including complaints against the police, one of the three models identified in this chapter, the IPCC operates within England and Wales<sup>1</sup>.

It is easy to understand why debates about UK policing tend to focus on England and Wales. Firstly, England and Wales dominates the UK in terms of population. Almost 90% of the combined UK population reside in England and Wales. There are therefore likely to be more people complaining about police misconduct in England and Wales than in Northern Ireland, which accounts for less than 3% of the UK population and in Scotland, which accounts for just over 8%.<sup>2</sup>

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<sup>1</sup> It should be noted that the IPCC takes measures to treat Wales separately from England and this is reflected in the recording of statistics.

<sup>2</sup> The UK population has grown in recent years but the distribution has not altered significantly the breakdown as established in the 2001 census figures, [www.statistics.gov.uk/census2001](http://www.statistics.gov.uk/census2001).

Likewise, the vast majority of British police officers are based in England and Wales. The number of full time equivalent police officers in England and Wales in 2010 stood at 143,734 (Sigurdsson & Dhani 2010), compared to 7,164 regular officers in Northern Ireland<sup>3</sup> and 17,409 officers in Scotland<sup>4</sup>. It is therefore likely that more police officers are going to do something that is objectionable, and/or deemed to dot7- so by a member of the public, in England and Wales than in the other constituent parts of the UK.

### **Police complaints in England and Wales: predecessors to the IPCC**

The introduction of the IPCC in 2004 marks a significant stage in the history of the development of police complaints systems in England and Wales. As Punch (2009) notes, it brought to an end 175 years of police complaints in England and Wales being dealt with through internal, as opposed to external, accountability mechanisms. Smith (2006) argues that such a change has been achieved via a series of stages that were structured around different legislative preoccupations at different moments in time. He identifies these as (1) establishing tripartite arrangements within police accountability mechanisms in the late 1950s and early 1960s; (2) introducing lay elements into overseeing complaints during the late 1960s and early 1970s; (3) expanding the regulatory powers over policing during the late 1970s and early 1980s; and finally (4), the process of civilianising police complaints procedures that has been most influential since the mid-1980s up until the present day.

The late 1950s and early 1960s are therefore an important starting point in considering the emergence of the IPCC. As Seneviratne (2004) notes, prior to the Police Act 1964 complaints made against police officers were treated as internal force matters and investigated accordingly. It is not until the Police Act 1964 that England and Wales had its “first statutory complaints system”, which was achieved by granting “chief officers sole responsibility for complaints and discipline” (Smith 2006, p.124). Furthermore, section 49 of the Act placed a requirement on chief officers to record and report on its investigations into complaints to the Director of Public Prosecutions and

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<sup>3</sup> Figures as of 1<sup>st</sup> September 2010, excludes full time reserves, part time officers and part time reserves that have played an important and contentious role historically in Northern Ireland. Source: [www.psn.police.uk/index/updates/updates\\_statistics/updates\\_strength\\_of\\_police\\_service\\_statistics.htm](http://www.psn.police.uk/index/updates/updates_statistics/updates_strength_of_police_service_statistics.htm)

<sup>4</sup> The Scottish Government, Statistics Release - Police Officer Quarterly Strength Statistics Scotland, 31 March 2010: [www.scotland.gov.uk/Publications/2010/05/27142939/2](http://www.scotland.gov.uk/Publications/2010/05/27142939/2)

furthermore to use officers from a different police force to conduct such investigations as and when it was deemed appropriate to do so (Smith 2006). This enabled a degree of externality to the processes of police complaints but was nonetheless seen by many to be insufficient (Seneviratne 2004). The Police Act 1976, which “was entirely devoted to complaints and discipline” (Smith 2006, p.124), addressed the matter by establishing the Police Complaints Board (PCB). The establishment of the PCB is seen as the first attempt to introduce a civilian oversight role in the police complaints system in England and Wales (Seneviratne 2004; Smith 2006) but was nonetheless heavily criticised and dismissed as ‘toothless’ (see Punch 2009, p.205). The PCB had no power to investigate complaints made against the police and was largely restricted to reviewing completed investigations (Smith 2006).

The PCB was replaced following the Police and Criminal Evidence Act 1984 (PACE), an influential piece of legislation in the history of British policing that was passed at a time of much social upheaval and a series of crises in British policing (Seneviratne 2004). PACE followed on from the Scarman Report 1981, which had criticised the police for failing to recognise the principles and values established within the Peelian ideal of Police as presented within the Metropolitan Police Act 1829 (see Waddington 1999; Reiner 2000). Part IX of PACE (Smith 2006) established the ground for a new body to take responsibility for dealing with complaints against the police and this was realised with the introduction of the Police Complaints Authority (PCA) in 1984.

As Seneviratne (2004) notes, two quite different models were considered at this time as possible replacements for the PCB. The idea of a model that would allow for independent investigations into all complaints was rejected in favour of the PCA model, which most significantly “provided for lay supervision for serious complaints” (Seneviratne 2004, p.334). Although the PCA came to be involved in overseeing high profile investigations, for example the “investigation into the West Midlands Serious Crime Squad” (see Punch 2009, p.205), it failed to establish itself as a legitimate and significantly independent body. Both Seneviratne (2004) and Punch (2009) make reference to the fact that the PCA itself recognised its own shortcomings. The Police Reform Act 2002 addressed these shortcomings following further criticism of the PCA’s lack of independence, in particular following the publication of the Macpherson Report 1999<sup>5</sup> and a ruling from the European Court of Human Rights, both of which expressed the view that England and Wales lacked a sufficiently independent body to investigate complaints against the police (Neyroud and Beckley 2001; Punch

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<sup>5</sup> Also known as the Stephen Lawrence Inquiry

2009). The IPCC was the result of ensuing discussions and following the Police Reform Act 2002 it became operational on 1st April 2004.

It is perhaps worth pausing for a moment before looking at the IPCC in any detail to reflect on Smith's (2006, p.125) analysis that presents the evolution of police complaints in England and Wales as "an unending cycle of scandal and reform" that has fostered a "trend towards non-police engagement". There are two points to note here. Firstly, that reform of the police complaints system is repeatedly motivated by crises in policing that lead towards greater levels of external oversight of policing practice. Secondly, and perhaps more significantly, Smith's (2006, p.124) analysis suggests that what he describes as a "police complaints reform cycle" is without end. In other words, the IPCC, like its predecessors, will succumb at some point in the future to pressures arising from police scandals that will lead to its demise and the introduction of a replacement body that is significantly more independent than the IPCC is itself. Given the extent to which public services are being subjected to considerable cuts as part of the coalition government's comprehensive spending review this is perhaps becoming a real concern for the IPCC, despite the fact that its future appears to be secure for the moment.

### **The transition from the PCA to the IPCC**

In one sense, the journey that resulted in the establishment of the IPCC began in the late 1950s. However, the political will to establish a complaints body that is independent of the police is more precisely rooted in the aftermath of the Scarman Report 1981. As Rowe (2007, p.xi) notes, the issue of introducing an independent complaints system as recommended in the Macpherson Report, "had considerable historical resonance", particularly in relation to Scarman. In many respects the debates that emerged following Macpherson necessitated a return to Scarman before progress could be made. By the late 1990s the PCA had lost the confidence of both the police and complainants alike and there was a perceived need to reconsider paths not taken at the time of Scarman. In this respect the PCA can be seen as a *wrong turning*. The need to go back to Scarman and revisit the complaints procedures had already been highlighted by the then Home Secretary, Jack Straw, in setting up the Stephen Lawrence Inquiry (Reiner 2000) and this became more apparent in other reports commissioned at the time to look at revising the complaints processes (HAC 1997; KPMG 2000).

The KPMG (2000) review into the feasibility of establishing an independent system had recommended the introduction of a new body, an Independent Agency for Complaints Against the Police (IACP), which created the

template for the final embodiment of the IPCC. The human rights organisation, Liberty, also published a report in 2000 entitled *An Independent police complaints commission*, which clearly influenced the Home Office, which published its thinking following consultation later in December 2000 in *Complaints against the police: framework for a new system*. The following year, in a document that set out future plans for policing in the UK, the Home Office (2001) stressed the need for a fundamental shift that required an opening up of the complaints system. They emphasised, for example, the need for complaints to be dealt with faster and to be accessible to wider sections of society. A Programme Board was set up by the Home Office in 2001 “to oversee the transition” from the PCA to the IPCC (PCA 2003). The result was the establishment of a new system for dealing with complaints, one that was much more clearly independent of the police. For Loveday (2000, p.214), the degree of independence granted the IPCC was representative of a shift in police accountability “not countenanced by the police service” two decades previously.

### **The Independent Police Complaints Commission**

The IPCC is a non-departmental public body but is dependent upon the Home Office for its funding (Clements 2006). The statutory powers and responsibilities of the IPCC are established within the Police Reform Act 2002. These were amended in 2006 and the IPCC since then also has responsibility for dealing with complaints made against the Serious Organised Crime Agency (SOCA), Her Majesty’s Revenue and Custom (HMRC) and the UK Border Agency (UKBA). Importantly, the Police Reform Act and subsequent amendments guarantee the independence of the IPCC and empower it to act as guardian of the police complaints system. It also places a duty on the IPCC to increase public confidence in the police complaints system. The IPCC has a Commission with a Chair, appointed by the Crown but accountable to the Home Secretary, and a minimum of 10 commissioners appointed by the Home Secretary (Police Reform Act 2002, c.30, Part 2). The first Chair of the IPCC was Nick Hardwick, who was selected in 2002 and began his appointment in 2003. He was re-appointed in 2008 and was to remain in post until 2013, but in 2010 he was appointed as Chief Inspector of Prisons. At the time of writing the Chair’s position is currently occupied by one of the two Deputy Chairs, Len Jackson. The majority of the commissioners are operational with responsibilities broken down by region. There are also two non-operational commissioners, who act to ensure that there are no conflicts of interests arising from the operational role of the other commissioners. Former police officers are not allowed to be part of the Commission to ensure its independence. In addition to the commission, the IPCC also has a Chief Executive, Jane Furniss, and a Management Board with five Directors in

addition to the Chief Executive. The Management Board is responsible for running the IPCC and supporting the Commission. An overview of the IPCC, which includes the names of the current members of the Commission and Management Board is available on the IPCC website: [www.ipcc.gov.uk](http://www.ipcc.gov.uk).

The IPCC works towards the general aim of improving public confidence in the police complaints system and does this through two major aspects of its operational functions. These are (1) related to its investigations and (2) its role as guardian of the complaints system.

The IPCC's role in handling complaints brought against the police varies according to the seriousness of the complaint. Importantly, the IPCC has no direct involvement in dealing with the vast majority of complaints, which are investigated by the police's own Professional Standards Departments (PSD). Nonetheless, the IPCC would see its guardianship role as being an important factor in setting the standards by which PSDs conduct local investigations and individuals who are unhappy with such local investigations have the right to appeal directly to the IPCC. When an allegation is deemed to be more serious it is referred to the IPCC who will decide whether or not it requires the IPCC's involvement. Again, the majority of cases referred to the IPCC by local forces are subsequently returned to the local force for them to carry out their own PSD investigations. Of those referred cases that the IPCC takes responsibility for investigating there are three levels of IPCC involvement.

Firstly, the IPCC has the option of taking responsibility for supervising a PSD investigation (supervised investigations). Supervised investigations and the general guardianship, standard setting role of the IPCC complaints are not new. The IPCC's predecessor, the PCA, operated in exactly this way (Seneviratne 2004). There are however two additional levels of IPCC involvement in investigating complaints that distinguish the IPCC's responsibilities from those of its predecessors. The IPCC has an increased role in managing PSD investigations (managed investigations) where it is deemed necessary and in the most serious of complaints, e.g. those involving death or serious injury, senior officers, serious corruption, allegations of racism or perverting the course of justice, the IPCC carries out its own independent investigations.

In 2009/10 there were just under 32,000 complaints made against police officers in England and Wales. Of these, 2,746 were referred to the IPCC

by local police forces<sup>6</sup>. The IPCC returned 2,208 of these back to local forces for the appropriate PSD to investigate. The IPCC supervised 207 PSD investigations, managed a further 151 PSD investigations and carried out their own independent investigations into 106 cases (IPCC 2010, p.16). These figures show that in terms of the number of investigations at least, the IPCC actually does little more than what the PCA did. The IPCC's investigative function beyond the supervisory role that the PCA also carried out is only apparent in 257 out of 31,747 cases. Of course we should not underestimate the actual significance of what is a very small percentage of total cases. It is after all the most serious cases that will attract publicity and it is against such cases that the IPCC's independence will be judged.

It should also be noted that there have been high profile cases for the IPCC to get involved with since its inception. Its first major challenge came from having to deal with the aftermath of the fatal shooting of Jean Charles de Menezes on 22 July 2005, just two weeks after the London bombings on 7 July 2005 and just one day after a failed repeat attack had been attempted. As Punch (2009) records, the Commissioner of the Metropolitan Police Service (MPS), Sir Ian Blair, initially adopted a position of non-compliance concerning the IPCC's review of the case and Blair asked for the suspension of the IPCC's legal requirements to investigate the incident. Blair was unsuccessful but Punch (2009) highlights the ambiguities in the legislation, not present in the Northern Ireland system, that allow for a degree of non-compliance under certain circumstances. On this occasion this ambiguity was not tested because Blair opted for suspension of the IPCC's legal requirement to investigate rather than invoking the chief officer's right not to cooperate with the IPCC under certain conditions (Punch 2009).

There have been other high profile cases that have tested the independent status of the IPCC. For example, IPCC (2010b) makes reference to the successful conviction on MPS Commander Ali Dizaei and the sheer volume of information gathered from complainants regarding the policing of the April 2009 G20 protests in London, which resulted in the death of Ian Tomlinson. Managing and analysing increasing amounts of information is a particular challenge for the IPCC, coupled with statutory requirements to disclose such information within investigations. The Chairman of the PCA, Alistair Graham, identified the statutory requirement for police and the IPCC to "disclose information to complainants on the investigation of their

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<sup>6</sup> Some complaints go directly to the IPCC. These are automatically passed to a local force for recording purposes and will then be referred back to the IPCC by the local police force if it is deemed appropriate to do so.

complaints” as one of the most significant features of the new police complaints arrangements to come into effect with the introduction of the IPCC (PCA 2003, p.11). One area in which the IPCC has focused its attention has been in relation to deaths in and following policing custody.

### **The IPCC and deaths in and following police custody**

Perhaps where the IPCC can claim to have made a most positive impact is in relation to the number of people dying in or following police custody<sup>7</sup>. There has been a steady decline year on year in this number in England and Wales, dropping from 36 in 2004/05 to 15 in 2008/09 (IPCC 2009, p.24). Although Nick Hardwick modestly acknowledges in his chair’s foreword to the IPCC’s 2009/10 Annual Report that it is unclear as to precisely what influence the IPCC has had upon this decline (IPCC 2010, p.7), it is nonetheless an area that the IPCC has invested its energies. For example, the IPCC conducted collaborative research with forensic medical examiners in London to identify common risk factors within the custody environment by studying examples that nearly resulted in fatalities, what they termed as ‘near misses’ (Bucke et al 2008). The research suggests that there are as many as 1000 near misses a year in police custody across England and Wales and that in 400 of these cases the likelihood of a death occurring was identified as being ‘likely or fairly likely’ (Bucke et al 2008, p.iv). The four most common risk factors that were identified by the study involved people attempting suicide and/or self harm, illicit drug taking, pre-existing medical conditions and, finally, alcohol consumption. Interestingly three out of four of these risk factors featured less prominently in actual deaths in or following police custody. The only risk factor where the opposite was true was in relation to medical conditions. This suggests that police officers are perhaps more conscious of the risks involved from detainees who are likely to inflict self harm and/or who show signs of substance abuse, but are less aware of the dangers associated with medical conditions, which feature more prominently in actual deaths than in near misses. Staffing shortages were identified as a significant challenge in dealing with near misses alongside better training, for example in relation to identifying medical risk factors.

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<sup>7</sup> This is defined within IPCC (2009) to include deaths that occur in the process of arresting or detaining a person in addition to the time a detainee spends actually in custody. It also includes deaths that occur following custody if injuries or medical conditions contributing to the death are identified or develop in the detention processes. Importantly, it also includes people detained under Section 136 of the Mental Health Act 1983.



The IPCC has also focused on the risk factors arising from placing people with mental health disorders in police custody as a place of safety. It is recognised that a significant percentage of people who come into contact with the police have mental health problems (Bradley Report 2009). Likewise, it is widely acknowledged that these individuals can often be very vulnerable. How the police deal with such individuals is attracting more attention in the UK and it is recognised at the same time that more needs to be done. The IPCC published its own findings into the issue of people with mental health disorders being placed into police custody for their own protection under Section 136 of the Mental Health Act 1983, using police custody as a place of safety (Docking et al 2008). The research showed that in 2005/06 over 11,500 people were placed into police custody for this reason. It was also noted that there were significant variations across police forces depending on the alternative arrangements that existed in respective localities. Docking et al (2008) concluded with recommendations that suggested more efforts and resources needed to be used to establish alternative places of safety, other than police custody.

### **The Police Complaints Commissioner for Scotland (PCCS)**

The PCCS is a non-departmental public body that became operational on 1<sup>st</sup> April 2007. It replaces the role of Her Majesty's Inspectorate of Constabulary Scotland in reviewing how police complaints are handled in Scotland. John McNeil became the Commissioner in 2009 and the PCCS employs only 16 people in assisting the Commissioner in his role. The PCCS stress their independence on their own website and emphasise their role in improving public confidence in the police complaints system in Scotland ([www.pcc-scotland.org.uk](http://www.pcc-scotland.org.uk)). The issue of increasing public confidence is also stressed in the PCCS's Annual Report 2009/10 (PCCS 2010a) and the impartiality of the PCCS is the focus of its Corporate Plan 2010-13 (PCCS 2010b). Perhaps of most interest in the Scottish example will be the extent to which police complaints fall more into line with other parts of the UK.

The model of police complaints in Scotland deviates from the model that operates in England and Wales, as with all police related matters, largely because of the constitutional anomalies that arose from the allowance of historical, local practices and traditions to remain in place following the Acts of Union in 1707, which saw the kingdoms of Scotland and England join together as Great Britain (Walker 2000). Indeed, Walker (2000, p.151) suggests that these anomalies arise from the fact that the UK is a "union state" that brought together distinct political entities with their own traditions and practices. Walker (2000) also suggests that Scotland was allowed to retain local traditions and practices because they were not

deemed to be of any major significance, especially considering that Scotland gave up its Parliament as a consequence of the Acts of Union 1707. A Scottish Parliament, with legislative powers, has been reintroduced following the Scotland Act 1998 as part of the process of constitutional devolution in the UK, but in many respects it is the permitted persistence of anomalies dating back to 1707 that have done more to shape the police complaints system in Scotland than the recent devolution. If anything, the introduction of the Scottish Parliament could do more to bring complaints in Scotland into line with the IPCC model, rather than accentuating differences, especially given the growing importance of the European Union in such matters. Indeed, a ruling by the UK Supreme Court on 26<sup>th</sup> October 2010 has challenged the anomaly that allowed Scottish police officers to question a detainee for up to six hours prior to the attendance of a solicitor (see BBC 2010). The inclusion of human rights into UK legislation certainly plays a role in eradicating such anomalies.

The issue of police complaints in Scotland has not received the same degree of attention that it has in other parts of the UK. As Seneviratne (2004, p.343) notes, the move towards developing an independent model of police complaints in Scotland, one that involves “some element of civilian input”, has arisen in spite of absence of any “major crisis in police complaints in Scotland”. Donnelly and Scott (2008) likewise argue that the introduction of the PCCS can only be partially understood as a consequence of dissatisfaction in Scotland with police investigating themselves. They argue that the existence of independent police complaints systems in other parts of the UK has also been a factor. Donnelly and Scott (2008, p.199) also argue that the PCCS’s role, which is “restricted to reviewing how complaints have been handled by police forces and to ensuring correct procedures are in place”, does not go as far as its counterparts in Northern Ireland and England and Wales. They stress this to the point of arguing that “Scotland is one of the few developed countries that does not appear to have a fully independent police complaints system” (Donnelly and Scott 2008, p.200). So, although Punch (2009) argues that the demand for greater external involvement in dealing with complaints against the police in the UK can be traced back to an incident that occurred in Scotland in 1957, the incident Punch refers to has been less influential in setting the parameters of police complaints systems in Scotland than in other parts of the UK.

### **The Office of Police Ombudsman for Northern Ireland**

Northern Ireland also deviates from the norms of England and Wales but in very different ways to that of Scotland and for very different reasons, as will be explained below. However, it is also worth noting that the population of Northern Ireland is only 1.7 million and in this respect it could be

seen as a minor player within the UK. On the contrary though, the extraordinary circumstances in which policing has occurred in Northern Ireland means that it has a disproportionate influence upon discussions of policing matters across the UK and beyond (see for example Home Office 2004; Law Commission of Canada 2006).

There has been little about policing in Northern Ireland that could be categorised as normal in relation to policing in other parts of the UK. Northern Ireland is from the outset a ‘contested “statelet”’ (Walker 2000, p.171), a product of the partition of Ireland following the 1920 Government of Ireland Act. Since its inception it has suffered ongoing and high levels of civil unrest and disorder that became especially violent during the period 1969-1998.

On the one hand there are simply more police officers in Northern Ireland per capita than in other parts of the UK. For example, the population of Kent in England is more than twice the population of Northern Ireland but there are more than twice as many police officers in Northern Ireland than in Kent. This needs to be put into some perspective though. For example, HMIC (2002) noted that there were 2,808 parades during 2001/02 in Northern Ireland. Although only around 1% of these ended in violent disturbances this still represents a need for public order policing on a scale that is far greater than anywhere else in the UK, including London. At the same time there were 2,393 officers permanently assigned to high level security provision in Northern Ireland, which would account for two-thirds of the entire force in Kent.

It is impossible to understand the police complaints system in Northern Ireland without appreciating both Northern Ireland’s violent history and the willingness and desire to move towards a more normal future as part of the ongoing peace process, in particular since the Good Friday (Belfast) agreement in 1998. The unique and exceptional nature of police work that has been dominant since the birth of Northern Ireland provides a political impetus to support the introduction of a police complaints system that can lay claim to being the ‘advanced model of police oversight in the world’ (Seneviratne 2004, p.338 citing Nuala O’Loan, the first appointed PONI). As Punch (2009, p.211) argues, it “was geared to an extraordinary situation”. Indeed, to put this into some context, Kempa (2007) argues that the introduction of the PONI was not the most radical aspect of Patten’s (1999) recommendations that were adopted. For example, the recommendations adopted on police recruitment in Northern Ireland and oversight of police policy both go beyond what is normal and acceptable in other parts of the UK.

Likewise, Patten (1999) had a significant impact on undermining the concept of *constabulary independence*, a long standing obstacle to having independent oversight of police misconduct. In replacing this term with *operational responsibility* (see Johnston & Shearing 2003), Patten has both appeased those who challenged the idea that the police in Northern Ireland were independent in any real sense and at the same time influenced discussions more generally about the possibility of sustaining the idea that police can be independent in any society. This had become a contentious issue in the 1980s (Smith 2004) and Patten (1999) helped to challenge those who used the doctrine of constabulary independence to retain autonomy and “a monopoly over disciplining their personnel” (Punch 2009, p.204). The focus on operational responsibility was supported by an approach to policing within the Patten Report that was underpinned by a commitment to human rights, which was supported and re-emphasised by Bowling et al (2006) in their study of the normalisation of policing and security in Northern Ireland. This focus also supported a more general assumption of public participation in policing matters (Neyroud 2001).

It should be noted that irrespective of the high level of support given to it, the PONI has had to face serious challenges in establishing itself as a legitimate institution. The starting point for the PONI was within a social setting in which the police attracted either a high degree of support or exceptional level of criticism depending upon which community was being surveyed (Brogden and Nijhar 2005). It is difficult to please everyone at the best of times but near impossible when starting from such a divided position. Accountability and consent are identified by Ellison and Smyth (2000) as key aspects of Patten’s strategy for overcoming such divisions but this has not always been easy, especially given the extent to which the PONI has had to be involved not only in handling contemporary complaints that have arisen since its inception and since Northern Ireland has been firmly on the road to peace, but also in reviewing cases that are very much situated in the heated contexts of the troubles at their very height. For Punch (2009, p.150), the “strong leadership” of Nuala O’Loan was an important factor in ensuring PONI survived early tests as it investigated controversial complaints that, for example, alleged police collusion with paramilitary organisations. O’Loan was the first PONI and she served in this position for seven years. Organisational memory is still an important factor within Northern Ireland’s police (Mulcahy 2000) and any questioning of the Royal Ulster Constabulary’s<sup>8</sup> professionalism is quickly “magnified into a series of causes celebres” (Ryder 2000, p.503). As

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<sup>8</sup> The Royal Ulster Constabulary (RUC) is the police organisation that the Police Service of Northern Ireland (PSNI) replaced following Patten (1999).

O’Loan’s replacement, Al Hutchinson recognises: “The Shadow of ‘the Past’ continues to hang over present day policing and is a barrier to sustained progress” (PONI 2010, p.4).

Dealing with the past is a role that the current PONI would rather not be lumbered with. However, the politically sensitive and contentious nature of Northern Ireland’s past is a difficulty that challenges all endeavours to move forward in Northern Ireland. For example, McEvoy et al (2002) highlight the extent to which critics saw Patten’s recommendations as so politically controversial that they were inevitably heavily restricted in their implementation. Nonetheless, Shearing and Wood (2007) emphasise that police governance in Northern Ireland and the public perception of its legitimacy have been enhanced significantly notwithstanding concerns raised in some quarters that Patten’s recommendations had been so severely diluted.

The early signs are that the PONI has been relatively successful, especially in terms of gaining the support of Nationalist and Loyalist communities in Northern Ireland and the police service (Seneviratne 2004; Punch 2009). However, Al Hutchinson, the current PONI recognises the significance of the challenge he faces in sustaining PONI’s momentum in the face of what appears to be a growing dissatisfaction with policing in Northern Ireland, which saw a 14% increase in complaints in 2009/2010 (PONI 2010, p.4).

Another significant development in the Northern Ireland context is that ‘Justice and Policing’ have been devolved in 2010 to the Northern Ireland Assembly and will no longer be accountable to the Secretary of State for Northern Ireland. As of 12<sup>th</sup> April 2010 PONI became a Non Departmental Public Body that is answerable to a newly formed Ministry of Justice within Northern Ireland.

The degree to which the complaints system in Northern Ireland is independent of the Police Service of Northern Ireland is highlighted as a template of good practice and offered as a model for police complaints systems to follow in the rest of the UK and beyond. The recognition of the importance of independence was already evident in the title of the PONI’s predecessor, the Independent Commission for Police Complaints (ICPC), even though the ICPC was in practice little different from the PCA in England and Wales (Seneviratne 2004). It has been much more necessary in the Northern Ireland context to demonstrate independence in deed rather than in title alone.

Whether or not it is realistic to think that a model for processing police complaints that arises from such extraordinary circumstances can be

realised in less dramatic political situations is open to debate. Irrespective of what one might think on the matter, the reality is that the PCCS and the IPCC suffer from comparisons to the PONI; they are judged against the independence of the PONI, rather than what has preceded the PCCS and IPCC or what is most appropriate and realistic within these very different settings.

### **The politics of police complaints**

The differences in the systems of dealing with police complaints in the UK are not merely technical, administrative inconsistencies but fundamental departures in relation to the most enduring aspect of discussions about police complaints, most significantly the issue of independent oversight. The particular differences within the UK's police complaints systems act as a general reminder that such procedures are highly political and reflect, therefore, the socio-historical and contemporary political settings that shape and contextualise what is, and what is not, acceptable police practice.

There are a number of common issues across jurisdictions related to police complaints. Perhaps the most enduring is the idea that the oversight of police and the responsibility for policing the police should be conducted by an organisation that is independent of the police. More will be said on this issue below. However, there are other matters that inform debates in the UK about police complaints that feature prominently and need to be considered here.

Firstly, there is a problem identified that concerns the degree to which complaints against the police are unsubstantiated. Bowling and Foster (2002), citing Lustgarten's (1986) seminal text on police governance, draw attention to the fact that either complainants against the police are invariably liars or the complaints system itself is seriously flawed. Of course there are complicating factors that need to be noted here. Firstly, police work traditionally has been largely unobserved (Reiner 2000) and therefore complaints are often difficult to prove as they are reduced to a police officer's word against the word of the complainant. This is certainly changing in that increasingly police work is observed through the lenses of CCTV cameras and the mobile phone cameras of independent witnesses and those being policed. Goldsmith (2010) has addressed the rise in the filming of the police and the use of other media through which policing is subjected to scrutiny, for example through social network sites such as *Facebook*. This development is certainly changing the landscape but bringing with it, at the same time, new problems. So, for example, we have gone from having no evidence upon which to judge a complaint against the police other than the complainant's testimony, to having far too much

evidence in certain circumstances because of the amount of footage that is handed over to the police. As Goldsmith (2010) notes, this was a particular challenge for the IPCC in the aftermath of the G20 protests in London in April 2009, which resulted in the death of Ian Tomlinson. The timeliness of investigations into police wrongdoing is also a concern, especially where complaints are unsubstantiated (Waddington & Wright 2008). The important point that is stressed in these debates is that a police complaints system loses its credibility and legitimacy if it only ever upholds a small minority of complaints. From this, the guardianship and raising public confidence roles of the IPCC, PONI and PCCS have featured prominently, which are concerned in different ways with ensuring the integrity of the complaints system is both upheld and seen to be so.

Public confidence in police complaints systems has certainly come to the fore in all three models within the UK. As Goldsmith (1995) notes, the lack of confidence in the police and the procedures for making complaints against them is an important factor in explaining why people do not bring complaints against the police. Sanders and Young (2008) also point out that people are not always aware of precisely what constitutes an example of a police officer misusing his or her powers (Sanders and Young 2008). This is particularly problematic in relation to anti-terror legislation that grants police wide-ranging powers. It is not always easy for citizens to be able to ascertain whether an officer has acted within the confines of the law or not and there are occasions when deciding on this matter requires some form of legal interpretation. There have been examples in very recent times of police officers in the UK abusing the powers granted to them under anti-terror legislation but this has only been established after the event and through the courts<sup>9</sup>. People are also not always sure of the procedures for making complaints against the police, although there is evidence to suggest that such awareness is increasing (Jones 2008). Increasing awareness is part of the responsibility the IPCC, PONI and PCCS have each taken on as part of their respective guardianship roles.

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<sup>9</sup> The European Court of Human Rights ruled against Kent Police's use of anti-terror laws in the policing of the Camp for Climate Action 2008 protests at Kingsnorth Power Station in Kent. The police were deemed to have used stop and search tactics under anti-terror legislation unlawfully, in particular against 11 year old twins, and generally against many of the peace protesters and photographers at the climate camp (see the Rob Evans and Paul Lewis article in The Guardian newspaper: <http://www.guardian.co.uk/uk/2010/jan/12/kingsnorth-stop-search-boys-illegal>)

The issue of confidence in the police complaints system does lead to consideration of a paradoxical relationship between the levels of confidence people have in the complaints system and the number of complaints that are actually made against the police. As Waddington (1999) points out, an increase in the number of complaints being made is quite likely a sign that more people are aware of the complaints system and furthermore, that they have sufficient trust in the system to go to the efforts of making a complaint. Conversely, the absence of complaints might be symptomatic of a situation in which the police and/or the complaints system are highly distrusted. The IPCC for example has seen a steady rise in the number of complaints being made and in the volume of referrals made by police forces to the IPCC since its introduction. In its Corporate Plan 2010/11–2012/13, the IPCC (2010b) notes that “the number of complaints and conduct matters referred” to the IPCC in 2009/10 was almost double the equivalent number for 2004/05, the first year of the IPCC’s operations. This is following a year-on-year increase. The IPCC’s (2009) publication of statistics for 2008/09 that highlighted an 8% increase in the number of complaint cases made and an 11% increase in the total number of allegations made against officers attracted much media attention, which implied that police officers were becoming ruder, less polite, less tolerant and generally less competent<sup>10</sup>. A counter argument might be that the ongoing increase in the number of complaints demonstrates that the IPCC is being seen as more legitimate than its predecessors. Of course it is not as simple as this and a rise in complaints needs to be considered alongside other factors before deciding whether it is a positive or negative development. The current concern with an increase in complaints in Northern Ireland is an example of the latter.

In this respect complaints against the police can also be seen as an integral part of the police’s learning capacity. It is worth noting here that police misconduct is, as Waddington (1999) notes, something that we should anticipate. The very nature of police work is dirty and as Newburn (1999, p.13), notes “complex ethical problems are an inherent part of policing”. Roach (2002) has stressed that this is especially the case within police investigations and he argues that the most serious forms of misconduct are particularly prone to occur in detective work. These observations are not, of course, peculiar to the UK. Goldsmith (1995, p.113) refers to the generalised experience of policing in different jurisdictions that confirm the “persistent and pervasive nature of police misconduct” as both an organisational feature of police units and as a general problem for society. It

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<sup>10</sup> See for example the BBC’s reporting of this: <http://news.bbc.co.uk/1/hi/uk/8272108.stm>



is unrealistic to assume that an effective police complaints system will lead to the eradication of police misconduct. Nonetheless, it is important to recognise the contribution that complaints against the police can have in addressing shortcomings in police practice and dissatisfaction with police practices amongst the populations being policed. The police can learn and develop from responding appropriately to complaints if they are understood as “units of feedback” (Goldsmith 1995, p.129).

Neyroud and Beckley (2001) argue that such feedback is an essential ingredient in the development of police practice. Indeed they even go as far as to provide a word of caution with regards to strengthening of the independence of those overseeing complaints against the police. While acknowledging that the strength of independent police complaints systems is largely determined by the extent to which they are independent of police control and influence, they suggest at the same time that this strength is also a potential weakness. They argue that there is a danger of this independence leading to a decrease in the learning opportunities for police and stress the need of ensuring that the independence of a police complaints system does not lead to a breakdown in communication between the police and wider sections of society.

Importantly, understanding complaints as an integral part of the police’s learning capacity requires us to see the goal of increasing the confidence in the police complaints system as a means towards increasing public confidence in policing, rather than an end in itself. As Goldsmith (1995, p.130) argues, there is an “incontrovertible” link “between information from the public, complaints procedures, and public confidence in the police”. Making the links between these three elements is crucial if the police are to develop and learn from the police complaints system.

### **The enduring issue of independence as a positive feature of police complaints systems**

The extent to which those conducting and overseeing investigations into accusations of police misconduct are independent of the police is perhaps the most significant factor recurring throughout debates about police complaints systems around the world (Goldsmith and Lewis 2000). This is also the case in the UK. Bowling and Foster (2002, p.1018), for example, refer to various surveys in the 1990s in the UK that demonstrated “almost unanimous support for an independent complaints authority”. This has been reaffirmed recently in a survey commissioned by the Association of Police Authorities that identified independent oversight of the police as a “particular focus” (NPIA 2010, p.22). But what form should the independence of such an authority take? And why is it important that such an authority should be independent?

Independence could be understood here as free from police control and influence. The logic underpinning this perspective is that such independence is necessary to ensure that complaints are treated objectively and with a degree of impartiality. This could be read to imply that the police *cannot* investigate themselves objectively and impartially. Given that objectivity and impartiality are such important qualities that we expect of police officers, the implication that the police are not objective and impartial when dealing with their 'own' is worthy of comment. Importantly, I stressed '*cannot investigate*' above as opposed to using '*have not historically investigated*'. The latter is an empirical statement drawn from examples from past experience of how complaints have been dealt with by police in different contexts; the former is a normative conclusion that transcends particular settings and makes a general statement about the possibility of police being able to act impartially when investigating other police officers. There is naturally a relationship between the extent to which the police have demonstrated a commitment to dealing with complaints in given contexts and the degree to which people within those contexts will believe the police to be capable of policing themselves in any context.

So, for example, it is understandable that in the context of Northern Ireland, a heavily divided political entity in which support for the police and distrust of the police are both exaggerated, the ability of the police to be impartial and objective is going to be questioned. This is a particularly difficult challenge for the PONI.

Likewise, in many urban centres across England and Wales the perceptions of individuals from Asian and Black ethnic minority groups will undoubtedly have been shaped by the experiences of being over policed and of not having complaints substantiated. Whitfield (2007, p.9) notes that the Police Act 1964 had acknowledged the need to take seriously the needs of complainants in the light of statistics that showed the vast majority of complaints made by Black or Asian people were unsubstantiated. This led to rights being established within the Act that allowed complainants to, for example, 'attend discipline hearings'. Clements (2006, p.87) notes that in relation to issues of diversity it is especially important that there is confidence across all sections of society in being willing to make complaints, in addition to knowing how to go about this and feeling sure that a complaint will be taken seriously. This has proven to be a significant challenge for the IPCC in England and Wales. For example, Chakraborti (2007) refers to an IPCC survey that revealed almost one in three Asian respondents feared some form of police reprisals if they made a complaint against the police. He also cites criticisms of the complaints process raised by the Islamic Human Rights Commission. Bowling et al (2008) also reiterate concerns made earlier by Bowling and Foster (2002) that there are

substantial structural barriers that the IPCC need to be able to overcome in order to address the persistence of inequalities in terms of how people from ethnic minorities are policed, particularly within custody and in the context of police stop and search practices.

At the same time it is worth remembering that the lack of evidence, which is independent of the complainant and the complained against, explains at least partially why so many complaints against the police have been unsubstantiated historically. This remains a challenge for investigators within a police complaints system that is independent of the police. In other words, acknowledging that the police have historically, to varying degrees and in different contexts, failed to act objectively and impartially when dealing with complaints, does not necessarily lead us to alternative approaches that will easily overcome the shortcomings of previous police complaints systems. Perhaps a more significant development arises from the expansion and normalisation of surveillance techniques across society that make it much easier to substantiate complaints, irrespective of whether the complaint is investigated by police officers or independent investigators. In other words, it might be objective and impartial evidence, rather than the objectivity and impartiality of the investigator that proves to be crucial in improving upon the poor rates of substantiated complaints against the police.

What is important to recognise in all of this is that being independent of the police does not necessarily in and of itself make it more or less likely that a complaint will be substantiated. Likewise, the perceived need to move away from the police being responsible for investigating themselves is not necessarily driven by crises or problems of such internally oriented practices, as indicated in the Scottish example.

### **Future developments in the police complaints systems in the UK**

It is worth recalling at this point Smith's (2006) cycle of reform, especially given the extent to which the UK is currently going through a major overhaul of public services as part of the coalition government's comprehensive spending review. The cost of having independent investigators was a factor in deciding the eventual level of independence that was granted to the IPCC. But as Punch (2009) argues, we live in increasingly litigious times and there may well come a time when the cost of not having independent investigators is far greater than the cost of having them.

It is also becoming more likely, as the coalition government tries to restrict the role of the state and increase governmental transparency, that the independence of a complaints system will be subjected to closer scrutiny. In

this respect it might no longer be acceptable for the Home Secretary to retain oversight of both the police and the organisation empowered to handle complaints against the police. Government abuse of such a dual role has been noted in other contexts, such as in Ireland (Walsh 2009).

This leads to a further consideration relating to the fact that individuals are currently appointed, as opposed to elected, into leading roles within police complaints systems in the UK. We should note that there is both a democratic aspect of policing the police, which implies the need to involve citizens and for them to actively participate in these processes, and a liberal dimension to this question, which emphasises more the need to constrain power. The fact that these positions are currently appointed, rather than elected suggests that it is the liberal, constraining factor that is most prominent in the police complaint systems in the UK, rather than the democratic, involving motivations. This could well change. Neyroud (2008, p.679), for example, has emphasised “lay oversight and inspection” alongside an “active citizenship” as important ingredients in realising public participation in policing. The more these qualities inform the idea of an independent police complaints system, the more likely it is that democratic pressures will be felt within the process of selecting those who will be involved in handling complaints against the police. This is already happening within the broader field of police accountability in England and Wales as evidenced by the coalition government’s commitment to replace appointed local police authorities with elected police commissioners as part of the tripartite accountability mechanisms.

### **Concluding remarks**

The UK provides an interesting study in how police complaints can be handled in different ways. What is most fascinating is the fact that despite the significant differences between the three models, particularly in relation to the question of independence, the three models are preoccupied with the same kinds of questions that are common in jurisdictions across the globe. Perhaps the most sobering point though is that it is difficult to understand a police complaints system in the abstract. It is significantly located in historical, but ever-changing settings. In one sense there are global trends towards greater independence for those handling complaints against the police and this is evidenced in all three UK cases. But how these pressures are manifested and how they actually impact on the adopted model provide little in the way of general lessons to be learned. For example, the lessons of the PONI mean little outside of the extraordinary contexts of policing in Northern Ireland. The existence of the PONI exerts pressure on the IPCC and PCCS but whether this can be, or indeed should be, sufficient to bring

about changes in Scotland or in England and Wales, never mind other parts of the world, is unclear.

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# **The Ontario Special Investigations Unit: Securing Independence and Impartiality<sup>1</sup>**

André Marin

It is imperative for the public to have confidence in the men and women charged with the responsibility of serving and protecting our communities. Without respect for the law and those who enforce it, there would be anarchy. However, there are times when the legitimacy of police conduct is called into question. In October 2007, Robert Dziekanski, a distraught and disoriented traveler from Poland, died in Vancouver after being tasered and forcefully restrained by RCMP officers, resulting in national protests and international condemnation. In August 2008, Freddy Villanueva, an unarmed Filipino youth, was shot and killed by police in Montreal, triggering riots. When these incidents occur, and they unfortunately do with some regularity, the public interest can only be fully satisfied by having a strong civilian oversight body in place to impartially verify whether those charged with upholding the law have crossed over the line into breaking it.

The public is justifiably suspicious of any oversight process that involves police investigating police. When police officials regardless of what force they serve on investigate their own, they are not only vulnerable to conscious and unconscious influences arising from their shared police experience, but also to the reasonable perception that their assessment of their brothers and sisters in arms may be improperly tainted.

Currently, Ontario is the only province in Canada that provides for criminal investigation of police officials by a civilian agency. Regrettably, Ontario's system has at times floundered, as a result of flaws both in its structural integrity as well as its operational culture, which have undermined its ability to function independently and impartially.

As a former Director of Ontario's Special Investigations Unit, I know first-hand the challenges faced by a civilian body when it is tasked with conduct-

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<sup>1</sup> Fall, 2009.

ing criminal investigations involving the police. In my experience, the most intractable and pernicious obstacle is the entrenched and often instinctive rejection by those in policing of any form of independent civilian oversight. Police opposition can manifest itself in many ways, from subtle passive non-compliance to outright refusal to cooperate. In order to overcome the blue wall of resistance, a police oversight body must operate within a statutory framework that provides the tools, including powers of compulsion, necessary for it to effectively fulfill its mandate, and with an organizational culture that is truly independent of those it oversees.

When I became Ombudsman of Ontario, one of the 500-plus government bodies that I had authority to investigate was the SIU. In June of 2007, after receiving a slew of complaints from affected individuals, family members, lawyers and community groups I launched a systemic investigation into the SIU's operational effectiveness and credibility. My investigation focused on the period subsequent to February 2003, since that was when the last external review of the agency had been conducted.

My investigation into the SIU, chronicled in my report, *Oversight Unseen*,<sup>2</sup> revealed a civilian oversight body struggling to assert its authority against aggressive police interests, absent a clear and comprehensive constituting statute, and without a strong operational structure. It also uncovered an organizational culture steeped in blue.

### **The legislative framework**

Typically, the creation of police oversight bodies follows controversy. In the case of the SIU, it emerged in 1990, in the wake of high profile police shooting deaths of racial minorities. While the government expressed commitment to a civilian oversight model at the time, the SIU's constituting legislation consists of a single section grafted on to the existing *Police Services Act*.

The SIU's mandate seems clear on the surface; it is to investigate the circumstances of serious injuries and deaths that may have resulted from criminal offences committed by police officers and to charge police officers, where there are reasonable grounds to do so. Members of police forces are also required to cooperate with the SIU's investigations. This scheme appears simple enough, but the lack of legislative direction and an effective mechanism to enforce compliance have provided opportunities for the overseen to derail the investigative process.

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<sup>2</sup> Issued September 2008 and available at: [www.ombudsman.on.ca](http://www.ombudsman.on.ca).

As Gareth Jones outlines in his chapter, from the outset, police officials actively resisted the SIU's investigative authority. In 1999, regulations were enacted addressing some of the areas of contention. However, despite this, the SIU and police officials continued to operate at odds within zones of ambiguity. When we commenced our investigation of the SIU in 2007, there was still significant disagreement regarding the scope of the legal obligations imposed on police officials in relation to the SIU. The uncertainties inherent in the legislative framework presented serious impediments to the SIU's ability to carry out its mandate effectively.

For instance, without a statutory definition of the types of "serious injuries" that trigger SIU involvement, the SIU and police officials have at times adopted conflicting interpretations. The SIU has also been reluctant, fearing police backlash in the absence of legislative entrenchment, to expand the operating definition of serious injuries it has used since 1991. As a result, the SIU has not considered serious psychological and soft tissue injuries or superficial gunshot wounds to be within its jurisdiction.

At the time of my investigation, the lack of clarity around what constituted serious injury continued to be one of the factors contributing to chronic delays in police notifying the SIU of incidents.

### **Notification delays**

It is imperative that criminal investigators arrive at the scene and commence investigating as soon as possible. It is well known in policing circles that "evidence very often evaporates, witnesses walk away, stories change ...scenes change."<sup>3</sup> In criminal investigations time is the enemy; evidence disappears and degenerates as quickly as it is created. Late notification of the SIU by police authorities can seriously hinder an investigation. In recognition of the need for urgency, since 1999 Chiefs of Police in Ontario have been required by the *Police Services Act* regulations to notify the SIU immediately of any serious injuries or deaths involving police. Despite this direction, during our investigation of the SIU, we learned that notification delays of hours, days and sometimes longer continued to be commonplace.

An analysis undertaken by the SIU of 28 Toronto Police Service cases from 2006 revealed that in all but two instances it took the service over an hour to notify the SIU. In most cases, notification was delayed for several hours, in two situations, the police waited over a day to call the SIU, and in a third, the call came in two weeks after the incident.

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<sup>3</sup> Julian Fantino, Commissioner of the Ontario Provincial as quoted in *Oversight Unseen* at page 31.

We also found close to 80 cases where the only reason the SIU became involved was because it learned about an occurrence through the media or other sources. In July 2008, for instance, the SIU read about an incident in the paper, after charges were dropped against two young males. The presiding judge had determined that the accused had been abused during their arrest. One of the men had apparently suffered a fractured rib, perforated eardrum and bruising around his eye. However, police officials had ignored their legal obligation to notify the SIU for the entire two years it had taken for this matter to proceed through the courts.

In some SIU cases, police authorities have excused their heel-dragging by blaming “confusion” about police protocols or the need to first confirm the extent of injuries before calling in civilian investigators. For example, in March 2006, Ontario Provincial Police officials claimed that a four-hour delay in notifying the SIU was justified because it wasn’t clear at first that a collision with a cruiser, which had left a motorist suffering seizures at the scene, and with a broken breastbone, clavicle and bruised lungs, and eventually led to the woman being placed in a medically-induced coma, had been “serious” enough to warrant calling the SIU.

In another case, a police service waited three hours before calling the SIU to advise that a 15-year old boy, who had been in custody, had died. The boy, who had a history of mental health problems, was arrested after a 911 call reporting that he had committed an assault and taken an overdose of his prescription medication. He was not taken to hospital, but kept at the police detachment until his mother arrived hours later to find him in physical distress. At that point, officers purported to release him to his mother’s custody, but then drove him on their own to the hospital in a cruiser. He died nine hours later of a drug overdose. Police officials maintained that the boy was not in their custody when he died. By the time SIU investigators had arrived, the witness officers were off duty, and the SIU had trouble locating the boy’s body, which had not been properly secured.

Remarkably, we found that even when it was blatantly obvious that the SIU mandate had been engaged, there were inordinate delays in notifying the agency. We reviewed 64 shooting incidents occurring from 2003 to mid-June 2007, and discovered that in almost a third of these it had taken the police an hour or more to notify the SIU. It took one service 90 minutes, on three separate occasions, to advise the SIU that its officers had shot civilians. Another police force delayed five hours in telling the SIU that an officer had shot a suspect in the arm.



Given the fundamental need for the SIU to be apprised of incidents within its authority as soon as possible, one would naturally expect that the agency would have taken swift and decisive action in the face of such persistent disregard for the legislative notice requirements. However, by the time my investigation of the SIU began in 2007, the organization appeared to be stagnant and acclimatized to complacency.

While the SIU had collected anecdotal information about late notification and was aware of problems with some services, it did not require its investigators to routinely seek or record reasons for police failure to comply with the notification requirements. In egregious cases, the Director of the SIU might write a letter to a Police Chief to politely raise a concern about cooperation, or more rarely, have a meeting with police officials, but this flaccid approach was largely ineffective. Faced with continued resistance, the SIU had largely come to accept notification delay as an inevitable fact of police oversight.

What was even more disturbing was that this defeatist stance appeared to reflect an even deeper attitudinal malignancy within the SIU. Over time, the SIU had come to internalize the belief that it was powerless to rigorously enforce its mandate. Rather than aggressively address challenges to its authority, it had adopted the spirit of compromise, conciliation and consensus in its dealings with police. This passive approach ultimately suited the SIU's parent ministry, the Ministry of the Attorney General, which had an interest in keeping a lid on any tensions percolating in the police community.

For years, certain vocal elements of the police community had argued that SIU investigations were not really like other criminal investigations, since they involve professional law enforcement officials, society's "heroes", not common criminals, and hence did not require the same exigency and rigor as investigations carried out by the police themselves. Unfortunately, our review of SIU cases and interviews with SIU staff, suggested that the SIU had actually bought into this misguided line of thinking.

### **Embracing complacency**

During our investigation, we found that despite the fact that the SIU's budget had doubled since 1998, it had continued to lose critical time in responding to incidents as a result of lax operational practices. We learned that instead of "blitzing" an incident scene and calling out as many staff as possible, as soon as possible, SIU managers followed a cumbersome routine of dispatching investigators at intervals, resulting in a staggered and delayed response. In addition, instead of ensuring that those closest in proximity to the incident were engaged, the SIU typically dispatched part-time staff,

instead of full-time investigators, who were closer to the scene, in order to avoid incurring overtime expenses.

In June 2004, Jeffrey Reodica, a 17-year old Filipino youth, was shot three times by a Toronto police officer, who had responded to a call concerning a fight between rival groups of teens. Mr. Reodica later died in hospital. It took the Toronto Police Service almost an hour to notify the SIU about the shooting. But to compound this initial delay, it took the SIU over an hour to call out all of the 10 investigative staff it assigned to the case. The first SIU investigator did not arrive on the scene until over two hours after the shooting, and the last to arrive showed up four hours after that. Instead of dispatching two full-time investigators, who were available that evening in the Toronto area, part time investigators were called out from hundreds of kilometres away. A number of 12 to 16-year-old youths were detained by police, without contacting their parents, well into the middle of the night awaiting SIU investigators. In at least one instance, it was shown that the delay had negatively influenced the testimony of a young witness.

We also found a number of cases in which the SIU had not bothered to obtain sufficient facts to determine whether a case required the Unit's involvement and had deliberately delayed responding to a notification. On March 6, 2005, the Toronto police called the SIU twice about an incident in which the police were on the scene when a father dropped his four-year-old daughter over a highway overpass, and then leapt to his death. The SIU did not inquire further. The next day, the police called again and explained that an officer had also phoned the suicidal man and that officers had been approaching him just before he jumped. However, we were told it wasn't until the Coroner's Office later called, concerned that the SIU had not attended the post mortem, that the SIU finally dispatched investigators. By then, there was no scene to attend and the SIU had to rely on police forensic evidence.

As further evidence of the SIU's indifference to conducting its investigations as soon as possible, SIU records revealed a disconcerting pattern of delayed investigation of serious injury incidents occurring over weekends.

We discovered that the thoroughness of SIU investigations had also been compromised on occasion by a lack of adherence to good investigative practices. We discovered a number of cases where potential witnesses and forensic evidence appeared to have been overlooked. In a SIU report from 2007, it was noted that the SIU team had missed various critical pieces of evidence, including a suicide note. We found that it was also very rare for SIU investigators to actually interview the officers most directly involved with an incident under investigation. While police officers, who are the

“subject” of an incident, are under no obligation to speak to the agency, obviously their evidence is extremely relevant. There was nothing to stop SIU investigators from inquiring whether a “subject officer” would be willing to be interviewed. However, the SIU did not encourage contact with subject officers following an incident. In fact, one SIU investigator we spoke with expressed the view that it was improper to interview subject officers and recalled turning a subject officer away who had attempted to explain what had happened at the scene of an accident. On June 20, 2006, a Toronto Police officer shot and killed Duane Christian, a 15-year-old black youth, as he was driving a stolen van, which had apparently veered towards another officer. Although the officer who had killed Mr. Christian advised the SIU that he was willing to testify, he was told that this was unnecessary.

In addition, we found that there were significant gaps in the investigative training provided to SIU staff. Some of the SIU investigators deployed to conduct sensitive sexual assault investigations had never received specialized sexual assault instruction, and a number of investigators appeared unaware of the full scope of the SIU’s charging authority.

What we found particularly astounding about the SIU’s lackluster approach to its investigations was its apparent rejection of the standard criminal investigative best practice of interviewing witnesses as soon as possible.

### **The toothless tiger**

Normally, in the criminal context, it is absolutely critical that key witnesses be interviewed right away, to limit exposure to outside influence, and the potential for witness accounts to change as memories fade. Consistent with this prevailing view, it has been a regulatory requirement since 1999 that police officers, who are witnesses to an incident being investigated by the SIU, submit to an SIU interview immediately upon request and no later than 24 hours after a request, where there are appropriate grounds for delay.

However, by 2007 the reality was that very few officer interviews ever took place within 24 hours. In fact, this appeared to the exception rather than the norm. The timing of interviews was left entirely up to the discretion of individual SIU investigators. Remarkably, some of the SIU’s investigators we spoke with considered immediate interviews of witness officers as “archaic,” “bad practice” and one intrepid investigator suggested that memories actually improve with time. At the same time, we heard conflicting views expressed by many SIU staff, including senior management. These individuals, while promoting investigator discretion with respect to witness officer interviews, also stressed those interviews

should be conducted immediately. Ironically, there seemed to be no debate that civilian witnesses should be interviewed as soon as possible.

One of the reasons suggested by a senior SIU official for the failure of the SIU to interview officers right away routinely was that there was no formal method of enforcing compliance. However, as we examined SIU records and interviewed investigators, it became quite clear that, in practice, late interviews were not simply a result of police refusal to cooperate without compulsion, but a courtesy readily extended by SIU investigators. We found that it was very common for SIU investigators to delay witness officer interviews for any number of reasons from claims that officers suffered from post-traumatic stress to a desire to work around police shift scheduling. It was not unusual for the SIU to oblige police services, which wished to keep overtime expenses down, by not requesting interviews with officers who were off duty. This meant that officer interviews could be delayed up to six days while the SIU waited for them to come back on shift. Another typical reason the SIU permitted interviews to be postponed was to allow witness officers an opportunity to obtain legal representation.

In Ontario, both officers who have witnessed an event, as well as those directly involved in an incident, are entitled to legal counsel. During the period we considered, the Director of the SIU had never exercised the regulatory authority to require a witness officer to attend for an interview without counsel to avoid unreasonable delay. In fact, it appeared to be generally acceptable for interviews to be delayed indefinitely to accommodate lawyer's schedules.

On November 4, 2005, 20-year-old Jason Steacy was killed by an Ontario Provincial Police officer investigating a report that Mr. Steacy had stabbed another resident of a trailer park. Two officers had entered Mr. Steacy's trailer and one had fired on him, after mistaking a computer mouse in Mr. Steacy's hand for a gun. The SIU did not begin to interview witness officers until six days after the incident and the last interview was not concluded until 69 days later. The interview of the only officer who had witnessed the shooting was delayed for a number of factors including his being off on sick leave as well as his lawyer's reluctance to agree to an interview. SIU management recognized that the delays in this case may have jeopardized the integrity of the witness recollections, but they appeared resigned to the fact that there was nothing they could do to speed up the process.

Our review of SIU data concerning the same 28 Toronto Police Service incidents from 2006 referred to earlier, showed that the SIU *only* interviewed witness officers on the same day as an incident had occurred in one case. In four cases, interviews took place within three days. However, in

most instances interviews were delayed not simply for days, but for weeks and even months. In six cases, witness officer interviews weren't completed until more than a month after the incident. In one case, two witness officer interviews did not begin until five months after an incident and were not completed until six months later. The SIU did eventually meet with the police service in question in an attempt to address the chronic situation of delayed interviews. However, clearly it had tolerated delay for a protracted period and its own approach to witness interviews had enabled the situation to continue unabated.

Even while it accepted that delayed interviews could interfere with the integrity of investigations, the SIU did little to counter this trend. It never emphasized that officer interviews should be conducted immediately except in exigent circumstances, and it had never directed that its investigators routinely obtain and record reasons for delayed interviews or notify management of problems with police non-compliance. Very few cases were ever flagged for senior management, and even when they were very little was ever done by the SIU to address the situation aside from referring to the problem in a report to the Attorney General or letter to a Chief of Police.

The SIU's practices around delayed officer interviews also served to undermine the regulatory requirement that witness officers be segregated to insulate their evidence from outside influence. Given that witness officers were usually permitted to leave an incident scene and that long periods went by before they were interviewed, the potential for conscious or unconscious tailoring of evidence was substantially increased. This risk was also compounded by the fact that many officers spoke with counsel before writing their notes and before speaking with the SIU, and quite often, the same counsel represented all officers involved in an incident, increasing the chance of contamination of their recollection of events, since lawyers are bound by the rules of professional conduct to share information among clients in a joint retainer situation.

We did find cases where the SIU had identified regulatory breaches relating to the segregation of officers and the preparation and production of police notes. However, in many instances the circumstances surrounding issues of segregation and preparation of notes had not been fully canvassed or recorded in the SIU's files. At the time of my investigation, systemic problems relating to the segregation and note-making practices, impacting the reliability of police witness accounts, continued to present significant challenges to the integrity of the SIU's investigations.

We received anecdotal and, at times, conflicting evidence from SIU staff concerning the degree of police resistance that they faced when conducting investigations. A study conducted by an outside researcher of more than 1,000 use of force cases investigated by the SIU between January 1, 2000 and June 6, 2006 suggested that about 10% of the cases reviewed involved some degree of police non-compliance.<sup>4</sup> However, the SIU did not have any comprehensive data regarding cooperation issues, and given the limitations of its computer system, it was unable to generally track and monitor non-compliance from a systemic perspective.

The SIU's preferred method for dealing with individual instances of police non-compliance was to identify concerns in reports to the Attorney General or in letters and meetings with senior police officials. During our investigation, we were advised that the SIU had deliberately chosen to follow a cooperative low-key approach to regulatory compliance, with admittedly mixed results.

The SIU would not publicize disputes with police services in the media, or pursue these in the courts. While it had considered seeking standing to address concerns through the police public complaints system, it had never done so. Ultimately, when its diplomatic letter writing and meetings failed, the SIU simply resigned itself to a state of stalemate. This had led to a patchwork of compliance. Some police services would cooperate with certain requests for information, for instance personnel and training records, and others would not. In addition, different forces had adopted different interpretations of what constituted police "notes" subject to production to the SIU. One hold-out police service had even doggedly objected to disclosing its policies and procedures to the SIU. Rather than engage in a more aggressive attempt to resolve this impasse, the SIU had simply resigned itself to "agree to disagree".

We found that the SIU was practically pathological in its avoidance of public controversy and consistently opted for the path of least resistance. The Ministry of the Attorney General, which stood aloof and beyond the fray, encouraged the SIU's non-confrontational stance. Despite being apprised by the SIU of systemic issues and concerns relating to police resistance, the Ministry was content to sit back and allow the SIU to limp along unassisted. We also found that the SIU's operational dependency on

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<sup>4</sup> Scott Wortley, *Police Use of Force in Ontario: An examination of data from the Special Investigations Unit – Final Report* (Toronto: Centre of Criminology at University of Toronto, 2006) at 52.

the Ministry was another factor limiting the SIU's ability to function independently and impartially in carrying out its mandate.

### **Too close for comfort**

The SIU is a relatively small agency, and has had to rely significantly on the Ministry for technical and administrative supports. While safeguards could have been put in place to limit the potential for this arrangement to influence the SIU's operations, instead, the Ministry and the SIU Director had entered into a very unusual agreement that had the potential to compromise the SIU's appearance of structural independence. Contrary to the normal practice applying with respect to the heads of independent agencies, when the Director was seconded from the ranks of the province's crown attorneys to serve as the head of the SIU, the Ministry and the Director agreed that the Ministry would carry out annual evaluations and award the Director discretionary merit pay contingent on his performance. While the Director received fluctuating incentive pay based on the Ministry's annual assessments, this was not supported by any formal evaluation documentation or objective evaluation criteria. The situation was clearly inconsistent with the need for the SIU to function within an operational framework reinforcing its independence and impartiality with respect to police oversight.

Public perception of a police oversight body is extremely important, and it is critical to avoid any suggestion that it might be subject to inappropriate external or internal influences. With this in mind, the *Police Services Act* contains provisions directed at mitigating police influence on the SIU.

According to the *Police Services Act*, no serving police officers can act as SIU investigators, SIU investigators are prohibited from participating in investigations relating to members of a force that once employed them, and the SIU Director cannot be a former police officer. Despite these statutory safeguards, during our investigation, the influence of police culture on the SIU was palpable.

### **Shades of blue**

At the time of our investigation, seven out of 12 full-time SIU investigators had come from civilian backgrounds. However, 24 of the 30 part-time investigators and 9 out of the 10 forensic investigative technicians were former police officers, as were all of the supervisors and the Executive Officer. Not only was the SIU investigative staff composed primarily of former police officers, but those officers tended to be white males in their 50s and older who had retired from policing. Given its staffing profile, the SIU was edging precariously close to perpetuating some of the stereotypes

that police forces had been slowly working to dispel through equity hiring programs. The presence of so many former long-serving police officers in the SIU ranks had a significant influence on its work culture and naturally sparked public speculation about its ability to act impartially in conducting investigations of police.

We discovered that in many respects the SIU looked and acted like a police force, from its dress code to its operational procedures. We were also told by a number of SIU witnesses that in some cases former officers working at the SIU had been known to use disparaging remarks, originating from the police community, to describe civilian victims and witnesses, and to use overly friendly leading questions when interviewing police witnesses. Some former officers were very blatant about their police affiliations, and were even in the habit of wearing police watches, ties and “thin blue line” rings while carrying out their police oversight duties. Such glaring symbolic displays of police solidarity were in sharp contrast to the independent and unbiased image that the SIU should have been projecting.

The SIU did little to dispel rumors that it was subject to police influence. The SIU’s commitment to keeping controversy out of the public arena combined with legislative limits on the information it could disclose about individual cases, left the public to assume the worst when it came to its decisions not to charge officers with offences. While the SIU published press releases at times, particularly in high profile cases, the basis for its decisions not to lay charges remained unclear. Only the Attorney General received the SIU’s detailed investigative reports, leaving those that had been injured, the families of deceased individuals, police officials as well as the general public in the dark. During our investigation, it was clear that the lack of transparency with respect to SIU decision-making had contributed to diminishing public confidence in the SIU’s ability to carry out its mandate impartially.

While during the period considered in my investigation, the SIU had directed considerable energy to solving its internal labour-management problems and improving its working environment, it had failed to tackle the underlying issues giving rise to its operational dysfunction, such as police non-compliance, which continued to threaten its effectiveness.

At the conclusion of my investigation into the SIU, I found that its failure to encourage compliance with and respond to breaches of regulatory requirements on the part of police officials rigorously, to ensure the most effective response to incidents, and to recognize and eradicate practices that undermined its credibility as an independent investigative body was unreasonable and wrong. I also found that the Unit’s practice of not



publicly disclosing Director's reports where no charges were laid was based on a legislative provision that was unreasonable. Finally, I was of the view that the Ministry's failure to take steps to ensure that the SIU had the necessary regulatory and operational supports to carry out its mandate effectively, and to establish a method of compensation for the Director that reflected the independent status of the SIU, was unreasonable and wrong.

I made 46 recommendations to address the concerns identified in my report. Twenty-five of my recommendations focused on the SIU itself, and were directed at instilling a sense of urgency and increasing the rigor applied to SIU investigations, eliminating practices that compromised the SIU's independence and impartiality, and increasing the transparency of its processes. I urged the SIU to respond quickly and forcefully when police services fail to comply with their statutory requirements and to respond to incidents with sufficient strength to ensure the integrity of investigations. I also called on the SIU to increase civilian representation in its management ranks.

I addressed six recommendations to the Ministry of the Attorney General. I encouraged the Ministry to properly resource the agency so that it could carry out its mandate effectively, to take a more active role in pursuing issues of concern regarding police practices, and to maintain a proper distance from the SIU to ensure its structural independence and impartiality.

Finally, I addressed 15 recommendations to the Government Ontario. In doing so, I emphasized that I believed that in order for the promise of civilian oversight of police in the context of incidents involving serious injury and death to be fully realized, it was necessary to reconstitute the SIU under new legislation dealing specifically with its mandate and investigative authority. I urged the Government to construct a strong legislative base for the SIU, which would include such features as an expanded definition of serious injuries coming within the SIU mandate, clear direction on the scope of police disclosure obligations, an effective method for enforcing police compliance, restrictions around legal representation of multiple officers, and greater provision for transparency.

I also requested that the SIU, the Ministry and the Government report back to me on their progress in implementing my recommendations. On March 31, 2009, I received status reports from both the SIU and the Ministry. Given the nature of the information received, it was necessary for my Office to conduct further review to assess the extent that the SIU and the Ministry had actually met their commitments in responding to my report. I

hope to report on my findings in the near future.<sup>5</sup> However, perhaps one of the best indicators that the SIU is beginning to move beyond its turgid state, is the backlash it has encountered while recently attempting to pursue its mandate with greater assertiveness.

### **The SIU begins to grow!**

With a new Director at the helm, the SIU has moved away from its previous practice of flying below public radar. It has increased the number of press releases it issues as well as the degree of information provided concerning its investigations. The Director has also become quite vocal about the police practice of consulting with a police association lawyer before preparing notes of incidents, which must then be turned over to the SIU.

In September 2009, the SIU Director issued a press release concerning his decision not to lay charges after conducting an investigation into the death of a 30-year-old man, who had been shot by an Ontario Provincial Police officer, after being approached about a stolen boat. The Director explained that because he was not sure what had happened, he could not conclude that there were reasonable grounds that a criminal offence had been committed. The Director was particularly critical of the fact that both the subject and witness officers had written up notes, which had been shared with the same legal counsel, before writing up the formal police notes, which were then shared with the SIU. The Director commented that he could not “place sufficient reliance on the information provided by the officers to decide what probably happened,” and observed:

This note writing process flies in the face of the two main indicators of reliability of notes: independence and contemporaneity. The notes do not represent an independent recitation of the material events. The first drafts have been “approved” by an OPPA lawyer who represented all of the involved officers in this matter, a lawyer who has a professional obligation to share information among his clients when jointly retained by them. Nor are the notes the most contemporaneous ones: they were not written as soon as practicable and the first drafts remain in the custody of their lawyer. I am denied the opportunity to compare the first draft with the final entries.

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<sup>5</sup> There have been a number of significant events since this chapter was written in 2009. In December 2011, I issued a second investigative report relating to the SIU, entitled *Oversight Undermined*, available at: [www.ombudsman.on.ca](http://www.ombudsman.on.ca).

Accordingly, the only version of the material events are OPPA lawyer approved notes.

The Director's very public condemnation of the practice relating to legal vetting of police notes prior to their release to the SIU prompted a swift counter attack by the Ontario Provincial Police Association. In a responding press release, the Association set out its take on the facts relating to the killing, which supported the view that the officers "acted in self defense." The OPPA expressed that it was "appalled" by the Director's comments implying that the officers' notes were drafted with the approval of their counsel, and noted that the Director's remarks had "put a strain" on the well established relationship that had previously existed between the Association and the SIU.

On October 5, 2009, the Director of the SIU issued a press release in which he outlined the developments at the Unit since my report. The SIU indicated that it now has a more formal process in place to monitor, record and deal with instances of police non-compliance with regulatory requirements, a reformed dispatch procedure, which includes the use of BlackBerrys by investigative staff to facilitate a continuous call-out of investigators in order to improve response times to scenes, and issues news releases in more cases and with more detail, in an effort to improve responsiveness to the public and affected persons.

To address concerns with public perceptions regarding the work of the Unit, the SIU also noted that it had taken steps to appoint an outreach coordinator, persons without police backgrounds are now represented within investigative management, and two new investigative trainee positions had been created and filled by investigators without police background.

While recognizing that it was equally important to provide investigators with discretion, the Director signaled agreement that witnesses should be interviewed quickly. He also indicated that he would exercise his authority under the regulations to suspend a witness officer's entitlement to legal representation if it would otherwise lead to an unreasonable delay. In addition, the SIU Director advised that he now routinely documents any problems with police compliance in Director's Reports to the Attorney General, in correspondence with Chiefs of Police and the OPP Commissioner and in discussions with police leaders.

The Director also reinforced his earlier public concerns about police note preparation practices. Later that same month, the Director went on the record again in an interview with a local reporter expressing concern that

lawyer vetted police notes “do not reflect the writer’s true recollection.” It was also reported that the Director had written letters of complaint to both the Ontario Provincial Police Commissioner and the Chief of the Toronto Police Service expressing concern about this practice. Apparently, the Commissioner had indicated that he would not be responding and the Toronto Police Chief had referred the SIU to the Toronto Police Services Board, which did not see any issue, but had not yet formally replied.

The media focus on this issue has continued as a lawyer for the families of two men shot dead by Ontario Provincial Police in the summer of 2009 revealed that they had approached the courts to ask that the way police lawyers handle SIU cases be changed.

During the extended period when the SIU was silent concerning disputes with police forces, we often heard from SIU and police officials about the spirit of cooperation existing between the police community and the SIU. However, now that the SIU has recovered its public voice, media reports are beginning to reference “the building tension” between the SIU and Ontario’s police forces. The war of words has continued as it was disclosed this Fall that compared to the three charges initiated by the SIU against police officials in 2008, the SIU had already laid 13 charges by October 31, 2009. The head of the 8,300-member Toronto Police Association blasted this SIU charge rate, claiming the new Director was carrying out a “political agenda” to “justify his leadership,” and that it was “a knee-jerk reaction to the Marin report.” The Association also indicated that because of concerns of “overcharging” and that some members had been “wrongfully charged,” it would be taking the “unprecedented step” of independently reviewing all cases of Toronto Police Officers charged by the SIU in 2009.

The dispute between the SIU and powerful police interests has even spilled into the political arena. In November 2009, a Conservative opposition member questioned the Minister of Community Safety and Correctional Services in the Legislature about whether he was satisfied that the SIU Director was performing his job in an objective and non-biased manner. This MPP also observed that the police community felt that the Director had lost his ability to remain objective and was clearly biased against police officers, and challenged the Minister to correct this “abuse of power.”

While police officials continue to give lip service to the importance of the role of the SIU, clearly the police community is not pleased with the prospect of a more energized oversight body. I believe that tension between police officials and the SIU is inevitable and that to a certain degree it is actually healthy. The current confrontation in Ontario is a natural reflection of a more emboldened agency attempting to assert its authority using the

limited resources at its disposal. Unfortunately, until the underlying legislative ambiguity is eliminated and an effective and efficient means of compelling compliance with the SIU is established, I believe that the SIU will continue to struggle to carry out its mandate against some of the most powerful interests in our society, police and their associations. Ultimately, I believe that a comprehensive and well-defined statutory foundation is necessary to enable the SIU to serve the public interest fully in civilian oversight of incidents involving serious injuries and deaths of those coming into contact with police.

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# The Top Ten Things Not to do when Setting up a Police Oversight Agency

Gareth Jones

## Introduction

If you are going to create a police oversight agency, do it properly or don't bother doing it at all. What happened at SIU is a salutary lesson.

The Special Investigations Unit (SIU) is an arm's-length agency of the Ministry of the Attorney General of the province of Ontario. It has a mandate to investigate the circumstances of serious injuries or deaths involving police officers. SIU was one of the first civilian agencies in the world given the responsibility to conduct criminal investigations into incidents involving police officers.<sup>1</sup>

SIU was created after a series of police shootings in Toronto in the late 1980s. Several of these involved black men and youths, leading to concerns from segments of the community that police were using disproportionate force against that group. A task force set up in 1988 to examine police oversight in the province noted an erosion of public confidence in police investigating police, and recommended that the government set up an independent agency to investigate police shootings. It suggested the unit be staffed by homicide investigators from a force or forces other than the one(s) involved in the incident under investigation, as well as 'at least two investigators drawn from civilian government agencies'.

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<sup>1</sup> To give some context, Ontario has a population of about 13.7 million. It has roughly 25,000 police officers that come under provincial jurisdiction, in 58 different police services, including the Ontario Provincial Police (OPP). In 1990, there were approximately 100 different police services—some having as few as 3 or 4 sworn officers. Royal Canadian Mounted Police (RCMP) members stationed in Ontario and First Nations police service officers are not subject to SIU oversight.



In 1989 and 1990, there were further police shootings, including one where a young black woman was shot and paralyzed. In May 1990, a 16-year-old black youth was shot in Toronto, bringing the issue of police investigating police to the boiling point. Legislation creating the SIU was rushed through the provincial legislature. It stated that the unit would be run by a Director who would be solely responsible for determining whether or not to charge police officers with offences arising out of incidents that fell within the mandate. The Director could not be a former police officer, and SIU investigators could not be serving police officers. If they were former police officers, they could not participate in investigations involving their former forces. Also, the legislation stipulated that all police officers must “co-operate fully” with the SIU.

The SIU came into being on September 1, 1990. It was designated an agency of the Ministry of the Solicitor General – the Ministry that was responsible for police across the province. A retired Ontario Court of Appeal judge, John Osler, was selected as the first Director. It took time to hire staff and set up an infrastructure. A Chief Investigator, a retired Metro Toronto Police Force homicide officer, was hired in October. As he could not investigate Toronto incidents – and the Toronto police was expected to be a significant customer by virtue of its size and the number of recent shootings there – a Senior Investigator was hired to deal with incidents involving Metro Toronto. He had no police experience. The only other permanent staff were an administrator on loan from the Ministry and a receptionist.

The powers that be decided that the SIU would hire investigators on an “as-needed” basis; that is, they would be contract employees who would only be called out (and paid) when an incident occurred. Some 15 were hired during December and January 1991. The majority were former police officers. The SIU began to conduct its own investigations in late January 1991, under an intense media spotlight.

Expectations were huge. The SIU began its work in an atmosphere of hope, hype and, on the part of some, horror. Within a matter of months, some community groups were calling for its disbandment because it had purportedly entered into secret agreements with the police. Simultaneously, some in the police community were demanding it be abolished on grounds of its alleged incompetence. Every media article about SIU invariably included the adjective ‘beleaguered’ when describing it. In very short order, SIU had become unloved and unwanted.

How did it happen? In this chapter, we will discuss how it all went terribly wrong, terribly quickly. There were fundamental flaws that plagued SIU

from the beginning – and very nearly destroyed it. Some were the responsibility of the politicians who created it, others were self-inflicted. Some observers concluded that many of these flaws had been deliberately built into the system by those who welcomed civilian oversight with as much delight as a dose of scabies. Others surmised that the rush to apply a band-aid to a politically charged issue had meant that no one had actually thought through the consequences. The conspiracy theorists – particularly some of the more jaded investigators on the front lines at the SIU – opined that the whole thing was a cunning ruse. The SIU had been set up to fail, they argued; at which point certain people could claim, “Hey look, civilian oversight was tried but it just can’t be done.”

The lessons learned do not just apply to police oversight agencies that have a robust investigative function, such as the SIU. They also apply, to varying degrees, to those that have a mandate to review or monitor police conduct.<sup>2</sup>

Herewith, then, the top 10 things *not* to do when setting up a police oversight agency:

### **1. Give the agency an uncertain mandate**

The legislation governing the SIU was drafted hastily. It was breathtaking in its brevity. Consisting of just one section, Part VII of the Ontario *Police Services Act*, it is comprised of a mere 9 subsections, running to a total of 227 words. Here it is, in its entirety:

- (1) There shall be a special investigations unit of the Ministry of the Solicitor General.
- (2) The unit shall consist of a director appointed by the Lieutenant Governor in Council on the recommendation of the Solicitor General and investigators appointed under the Public Service Act.
- (3) A person who is a police officer or former police officer shall not be appointed as director, and persons who are police officers shall not be appointed as investigators.
- (4) The director and investigators are peace officers.
- (5) The director may, on his or her own initiative, and shall, at the request of the Solicitor General or Attorney General, cause

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<sup>2</sup> In fact, they apply to virtually any oversight agency in any field.

investigations to be conducted into the circumstances of serious injuries and deaths that may have resulted from criminal offences committed by police officers.

- (6) An investigator shall not participate in an investigation that relates to members of a police force of which he or she was a member.
- (7) If there are reasonable grounds to do so in his or her opinion, the director shall cause informations to be laid against police officers in connection with the matters investigated and shall refer them to the Crown Attorney for prosecution.
- (8) The director shall report the results of investigations to the Attorney General.
- (9) Members of police forces shall co-operate fully with the members of the unit in the conduct of investigations.

That was it. No definition of “serious injury.” It hamstrung the Director on what actions he or she could take after an investigation. Most importantly, there was no regulation setting out how the investigative process was supposed to work. The legislation raised more questions than answers, including:

*What are the obligations of an officer whose conduct is under scrutiny?*

There is nothing in Part VII of the Police Services Act that deals with the rights and responsibilities of officers who become the subject of SIU investigations. Police officers have a lot of latitude to use force, even lethal force, when they think they have to, even though in the cold light of day they may be wrong. The law understands that police officers sometimes have to make split-second decisions that can have life-changing consequences. That doesn't give them *carte blanche*, of course – the decision must be reasonable, both objectively and subjectively.

It follows, then, that in SIU investigations, generally the most important thing to ascertain is what was going through the officer's mind as he or she pulled the trigger, continued the pursuit, used the Taser, locked the cell door, carried the prisoner into the station, broke the speed limit on the way to a call for urgent assistance, or took whatever action led to the incident under investigation. Knowing what the officer was thinking is especially important when there is little in the way of other evidence to assist investigators in determining whether the officer's actions complied with the law.

But to what degree should “subject” officers, i.e., those who may – repeat, *may* – be charged with a criminal offence as a result of an SIU investigation, be obliged to submit to interviews by SIU investigators? How do an officer’s *Charter* rights fit into the equation? Should it be a condition of employment that a subject officer must provide a statement? What protections should subject officers have? What obligations should they have, considering the special powers that they are given, including the power to use lethal force in certain circumstances?<sup>3</sup> Should subject officers be obliged to “fully co-operate” as the Act would appear to stipulate?

The debate is ongoing. A fundamental problem with Part VII is that when it was enacted, it did not make clear to what extent a subject officer had to co-operate with the SIU. Nobody made the rules clear. Nobody dealt with the expectations in many segments of the community that the SIU would have the power to require subject officers to give a statement. Nor was it clear who had the authority to determine who was a subject officer. Was it the SIU? The officer? His or her counsel? The Chief of Police? The police union?

*What is a “serious injury”?*

If you are going to build a “serious injury” threshold into the legislation for your oversight agency, then define it as precisely as you can. An astonishing amount of time, money, posturing and effort has been spent arguing over what is or is not a serious injury that should concern the SIU. Does a broken metatarsal meet the threshold? What about a concussion that requires observation at, but not admission to, hospital? A bruise on an eye that looks like something out of *Saw III* in photographs taken a couple of days later but, medically, is just a contusion? A barely visible flesh wound caused by a police bullet?

When the SIU began operations, police tended to take a fairly narrow view of “serious injury,” while the SIU took a broader position. What became known as the “Osler Definition” of serious injury (named for the first SIU director) mirrored the legal definition of “bodily harm” pretty closely<sup>4</sup>. Yet

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<sup>3</sup> If the SIU has reasonable and probable grounds to believe the subject officer has committed an offence, the officer will be cautioned and is under no obligation to provide a statement.

<sup>4</sup> Serious injuries “shall include those that are likely to interfere with the health and comfort of the victim and are more than merely transient or trifling in nature....serious injury will initially be presumed when the victim is admitted to hospital, suffers a fracture to a limb, rib or vertebrae or to the skull, suffers burns to a major portion of the body or loses any portion of the body or suffers loss of

even the police generally accepted that a graze from a police bullet triggered the SIU's mandate, even if a broken nose during an arrest did not. That lack of a definition left all sorts of questions up in the air. What happens if the extent of the injury was not immediately clear? For example, should the SIU be notified when there was no visible injury but a person was being taken to a hospital to be checked for internal injuries? This is a very important call, because as in any investigation, time is of the essence<sup>5</sup>. Evidence is perishable. It evaporates as police forces decide whether or not to call the SIU. Minutes matter.

*When should police notify the SIU about an incident?*

Part VII is silent on this important question, leading some police forces to develop complex internal notification processes. When an incident happened, the supervisor at the scene was required to inform the duty inspector, who in turn notified the SIU liaison officer, who then called the Deputy Chief, who then called the Chief, who then authorized that the SIU be informed, or even made the call personally. All that took time – sometimes well over an hour, or even more if there was a debate as to whether the injury was “serious.” Although most police forces were very good about notification, a few acquired a reputation for being slow. One force became notorious for calling the SIU at the last possible moment. Their liaison person might report to the SIU: “We weren’t quite sure if it was a serious injury when the incident occurred yesterday and it still isn’t absolutely certain, but we thought we’d let you know just in case.” But to the more cynical SIU investigators, what this really meant was that the post-mortem was probably already underway.

*What happens when the police are investigating a crime arising out of the same incident?*

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vision or hearing, or alleges sexual assault.” This is from the Standard Operating Procedure (SOP) agreed upon between the SIU and police on April 14, 1992 and made public as what the media dubbed “The Secret Protocol” as discussed below.

<sup>5</sup> That said, if the goal is police accountability, a thorough, independent investigation into an alleged beating of someone who has failed the “attitude test” during a routine arrest that leaves few visible injuries and no broken bones, may (or may not) expose more rogue police officers than a fatal shooting. Is it the severity of the injury or the circumstances of the event that should take precedence?

Unsurprisingly, a huge proportion of incidents investigated by SIU start out as police investigations of civilian crimes – the suspect is often the one who ends up being killed or injured, for instance, during a police pursuit or arrest. Whose investigation takes precedence – that of the police or the SIU? Who has first crack at witnesses, who gathers and submits what evidence for what kind of testing? Who shares what information – and when? Obviously, if the alleged “bad guy” is dead, the SIU’s investigation takes precedence. But what if a wounded person is suspected of very serious offences, perhaps, as in one SIU case, the murder of a police officer? Who runs the show then?<sup>6</sup>

*What discretion should the SIU Director have in laying charges?*

It wasn’t just a lack of clarity and detail in the legislation that created problems. It was also a fettering of the Director’s decision-making, specifically the use of the word “shall” in reference to the Director deciding to lay a charge. It is an uncompromising word, leaving no room for discretion. A police officer could be on his or her deathbed, but if the Director has reasonable and probable grounds to believe that the officer has committed an offence, out, in theory, come the handcuffs. Even if the Director is convinced that there is little or no possibility of a conviction – or it is not in the public interest to do so – he or she must charge the officer.

This may or may not be a bad thing. It may be that it was designed to stop the Director from taking the easy way out. But if SIU is supposed to be the vanguard of not merely independent investigation but also more open and transparent investigation, then perhaps a more reasonable approach would be that the Director be given discretion in laying charges – but be obliged to explain his or her decision in as much detail as possible to all SIU’s constituents, especially the public.

All of these questions raised by the lack of clarity in the SIU’s mandate quickly led to another well-intentioned fiasco. Judge Osler, the first SIU director, met with the Ontario Association of Chiefs of Police very shortly after SIU began operations. They negotiated a set of procedures to govern situations that were not spelled out in the legislation – i.e. virtually everything.

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<sup>6</sup> In that case, it was the police, which is exactly how it should be.

They came up with a document that eventually became known as the Standard Operating Procedure (SOP). The SOP set out guidelines as to what should happen in given situations, including:

- Who had precedence in an investigation;
- Sharing of witness interview statements;
- How forensic evidence would be shared;
- A definition of “serious injury” (later known as the “Osler Definition”), and
- Investigations of off-duty officers. (It was agreed that the SIU would not investigate “incidents involving off-duty officers in the course of their private lives,” which meant that if a police officer beat his or her spouse or killed someone while driving drunk off duty, the SIU would have no role. Such cases would still involve police investigating police.)

Judge Osler made it abundantly clear that the SIU could override the guidelines if the Director thought fit. The set of procedures was sensible, given SIU’s anorexic resources and bloated mandate. Problem was, it was done behind closed doors and without input from other interested parties. A major newspaper started sniffing around and obtained a copy of the SOP. On July 13, 1991, it broke the news, dramatically dubbing the agreement “The Secret Protocol”. The coverage was severely critical, accusing the SIU of selling out to the police. Opposition politicians joined in the fray, denouncing the protocol: “To do something like a secret agreement is to strike at the heart of its independence and what the Unit is designed to do,” wailed one. Said a community activist who had lobbied hard for the SIU’s creation: “I think the Unit should disband and send everyone home. It’s a total waste of taxpayers’ money” (Toronto Star, 1991).

## **2. GIVE UP CONTROL OF INVESTIGATIONS**

For an investigation to be credible, the investigating agency has to keep control of the process. To do that, it has to adhere to these eight principles:

1. The investigators must be as independent as possible.
2. The investigators must be trained and experienced.
3. All potentially relevant issues must be identified and, where appropriate, pursued.
4. The investigation must be sufficiently resourced.

5. All relevant physical evidence must be identified, preserved, collected and examined as necessary.
6. All relevant documentation must be secured and reviewed.
7. All relevant witnesses must be identified, segregated where practical and thoroughly interviewed.
8. The analysis of all the material gathered in the investigation must be objective and based solely on the facts.<sup>7</sup>

Unfortunately the SIU, in its early years, failed this on several counts, to varying degrees. It was top-heavy with ex-police (including me), which, while not necessarily a bad thing, did compromise perceptions of independence. Training and experience was an issue for some investigators – both from civilian and former police backgrounds, who did not have enough of either.

The big issue was, of course, resources – the laughable lack of which led, inevitably and unsurprisingly, to deficiencies in the evidence gathering process, which in turn undermined police and public confidence in the competence of SIU investigations. In many cases, the SIU lost control of investigations because it didn't have enough resources to cover all the bases.

The most significant loss of control, in my opinion, was that it had to rely on police services to collect and submit physical evidence. Physical evidence is absolutely crucial in police oversight cases. Blood spatter, gunshot residue, motor vehicle collision reconstruction, scene diagrams, photography and video, fingerprinting, DNA, etc., are central to any criminal investigation. It was not until late 1992 that the SIU began developing its own in-house forensic investigation capacity. This added tremendously to its control of investigations.<sup>8</sup>

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<sup>7</sup> These principles and how they apply to police oversight are discussed in more detail in a book by the author (2009) entitled *Conducting Administrative, Oversight and Ombudsman Investigations*. It is published by Canada Law Book and available at [www.canadalawbook.ca](http://www.canadalawbook.ca). It also has a lengthy chapter on police oversight, entitled “Investigating the Police”.

<sup>8</sup> Today, the SIU has two full time forensic identification supervisors who oversee nine as-needed forensic identification investigators.



Another important aspect of maintaining control is avoiding joint investigations. Unless you have absolutely no other option, do *not* engage in joint investigations with the police force you are investigating. Don't negotiate control. Don't let police sit in on interviews. Don't let them attend post mortems. Don't share documents. The early years of SIU are littered with cases when the integrity of the investigative process was undermined this way. It fed the misconception that the SIU was not capable of doing investigations itself.

Above all, don't do joint press conferences. Shortly after 3 a.m. on May 2, 1992, a Toronto Police officer shot and killed Raymond Lawrence after a short foot pursuit. A knife was recovered from the scene. The SIU later determined that Mr. Lawrence, who was black, was an accomplished crack cocaine dealer.

The shooting happened two days after the acquittal in Los Angeles of several officers involved in the notorious Rodney King beating, which led to riots that killed dozens of people. Tensions between police and the black community in Toronto were also high. Immediately after the shooting, some community activists jumped to Mr. Lawrence's defence, alleging that he was an innocent victim of a brutally racist police force. Toronto's Chief of Police entered the fray. "There is no other time I can recall where I would suggest to the members of the public and to all communities that we must remain calm," he told the media (Toronto Star, 1992). SIU Director Osler was persuaded to appear at a press conference with the Chief, sitting on the same platform. They both assured the public that there would be a full and independent investigation into the incident.

It was a disaster. The spectacle of them sitting side by side completely negated the message that SIU was an independent oversight agency, at least in my view. The optics were awful, regardless of the participants' good intentions. It looked as though the overseer was in cahoots with the overseen. Several days later, Toronto experienced its first riot since the 1930s, after a demonstration about the shooting on Yonge Street. Director Osler later admitted that the joint press conference had not been a good idea.

Despite all this, the SIU always met the eighth principle of credible investigation: Objective analysis of evidence, based entirely on facts. Director's decisions were unfailingly based on the facts and the facts alone, at least in the cases I was involved in. In the Lawrence case, Director Osler ultimately found that the officer had ample grounds to shoot Mr. Lawrence, including not inconsiderable evidence that he was running at the officer with a large knife when he was shot.

I worked for 11 different SIU directors, and never saw one make a decision – on whether or not to charge an officer – based on political, police or special interest group pressure, expediency or self-interest. In fact one Director confided that his decision to charge an officer in a very sensitive, high-profile case would probably get him fired. He was right.

This is not to say that SIU investigators and Directors invariably saw eye to eye. In some cases, investigators disagreed with the Director's decisions, but reasonable people can reasonably differ. Directors' decisions were final and, at least in my experience, were always based on the evidence at hand.

### **3. STAFF THE AGENCY EXCLUSIVELY WITH POLICE OR EX-POLICE**

If you have serving police officers doing the investigative work for your nominally independent police oversight agency, you have a massive, possibly insuperable, credibility hurdle to overcome. However you frame it, it is police investigating police. It is not a *civilian* oversight agency, nor should it be billed as such.

The danger in having ex-police on board is the same as having serving police conducting investigations: Perception. It will be difficult to convince anyone that your investigations are fair if your organization is perceived to be a rest home for retired police. It will be a bit of a credibility challenge if your investigative staff is made up primarily of white, aging men sporting ties with police crests on them and not at all representative of the community at large.

When the SIU began, it was loaded with just-retired police, many of whom had held high-ranking positions<sup>9</sup>. That created concerns from some of the community groups that had fought so hard for the SIU to be established. But some within the police world also took umbrage, particularly when the SIU's competence was called into question. One senior officer told the press that the SIU should have “the best investigators, not recycled ones” – which was a bit harsh, considering SIU investigators at that time included a couple of his former homicide squad colleagues, both with stellar records.

Underpinning the debate was the received wisdom that police can investigate police. Only they have the skills, the talent, the “walked a mile in my shoes” experience necessary to understand why an officer shot the suspect in the back alley, or put the prisoner in a cell or chased the bad guy along

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<sup>9</sup> Given that investigators were contracted on an as-needed basis, with no guarantee of work, these positions were ideally suited for retirees and not particularly attractive to anybody else, which is a problem in and of itself.

the freeway, or Tasered the guy with the stapler, or whatever else. So, the argument goes, civilians can't be qualified to conduct criminal investigations of police. They just don't have the competence, the understanding or the experience. If you create a civilian oversight agency, it had better be staffed by serving police or ex-police. A token "civie" in the mix is fine, but only those who have stood shoulder-to-shoulder on the thin blue line should run the show, or at least the investigations.

A lawyer working for a police force, a former officer himself, once put it this way: "Police are like seasoned surgeons, while Special Investigations Unit investigators are like first-year medical students. Who would you rather have operating on your brain?"

This argument is absolute rubbish, with all due respect. Investigators from civilian backgrounds make just as good investigators as police or ex-police, for a number of reasons.

First, it *isn't* brain surgery. These are not complicated investigations, however much vested interests would like to spin them as such. In fact, they are relatively simple. For sure, the implications can be profound – an officer's career, the reputation of a police service and the confidence of the public are at stake. But the evidence needed to establish the truth is usually easy to identify and secure, if everyone co-operates fully. The officer who pulled the trigger, drove the police vehicle, or monitored the cell is always identifiable and, at least in theory, immediately available for interview. Often, a significant number of the key witnesses are police officers – not exactly difficult people to find. Documentation – police notebooks, computer records, duty statements, policies and procedures, use-of-force training records, etc. – is not usually hard to get. The internal communications tape, which often forms the evidentiary backbone of an investigation, is easily obtained.

These investigations are not "whodunits". A fatal police shooting is rarely more difficult to investigate than a domestic homicide where the spouse admits to pulling the trigger. There can be a time-consuming process to be followed and painstaking evidence collection, absolutely – but no need to draft in Sherlock Holmes.

Second, SIU investigators will rapidly acquire more experience in conducting investigations into police-involved deaths or serious injuries than any serving police officer ever will. In Ontario, police do not do these investigations anymore. SIU deals with roughly 200 incidents annually. A rookie SIU investigator will be involved in many of those cases over the

course of a year, eventually becoming a lead investigator in a major case. It is a very sharp and usually a very effective learning curve.

Third, the interviewing skills required come very quickly. There are five principles that underpin any good interview:

1. Be prepared.
2. Establish a rapport with the interviewee.
3. Be thorough.
4. Be objective.
5. Maintain control of the interview process.

In my experience, it was the SIU investigator's attitude that mattered, not where he or she had been previously employed. Some of the ex-police officers were very good interviewers – smart, measured, impartial and active listeners. Some civilians were as good as ex-officers; some were better, some were worse. It did not depend on background; rather, it depended on how much the investigator wanted to dig down to the truth.

Finally, not being an ex-police officer had its advantages, as became apparent when interviewing individuals involved in an incident who were not necessarily model citizens. Once they learned the SIU investigator was an ex-police officer, such people would often be afraid to be candid. The same applied to family members of those killed or injured – once they learned the investigator was a former police officer, their faith in the objectivity of the investigation was palpably diminished in many cases. It took some effort to rebuild trust and confidence. Civilian investigators did not carry that baggage.

I am not for a moment suggesting a blanket prohibition on a civilian investigative agency employing former police officers. I worked with some truly superb ones at the SIU. As long as they are totally objective, they are a huge asset. In the case of forensic identification officers, it is almost inevitable that they will be ex-police. The work is very specialized, technical and painstaking. Processing a scene – and spending a few days in the witness box explaining what you did and why you did it – is not a game for amateurs. It is very difficult – though not impossible – to find a civilian who has the requisite technical knowledge and experience for these tasks.

*Civilians have to be properly trained and experienced*

Much depends on the level of training and experience civilians have when they join SIU. In the very early days of the SIU, there were one or two civilians with no police background who were thrown, without significant

training or experience, into the deep end. Some did not know, literally, their posterior from their anterior, which was a bit of a problem when it came to describing entry and exit wounds. It was even more embarrassing when this lack of knowledge made front-page news. One civilian investigator was once asked at the scene of a shooting by police forensic identification officers what tests he wanted the Centre of Forensic Sciences to conduct on various exhibits. He replied, “The usual and the unusual.” That spread rapidly among police ranks and did not exactly enhance confidence that the SIU knew what it was doing.

Today, all new SIU hires have some kind of investigative track record. They come from the myriad government and private agencies that do fact-finding. Some of the SIU’s most competent investigators have extensive experience conducting compliance and regulatory investigations. In the U.K., former customs officers have proven to be very good investigators for the Independent Police Complaints Commission (IPCC), according to former IPCC Commissioner Nicola Williams<sup>10</sup>.

*But, you will need police from which to start*

That said, any police oversight agency that is tasked with conducting criminal investigations will undoubtedly need significant input from experienced criminal investigators at the outset. The SIU benefited hugely by the fact that the first Chief Investigator was Gord Wilson, a recently retired Toronto police inspector who had extensive homicide experience. Far more importantly, he believed that the SIU was a good idea in principle and that if it was going to do investigations, it should do them properly. He recognized that the SIU would have little credibility if it was staffed exclusively by ex-police officers. However, he also knew that until it found its feet, civilian investigators needed time to get to know the ins and outs of conducting criminal investigations.

So, any new police oversight agency that conducts criminal investigations will need experienced criminal investigators on board at the start. But if the goal is to have a truly civilian unit, then one of the primary tasks of the agency should be to identify and train individuals who have never been police officers, and who have the aptitude to conduct investigations. Luckily, that is not especially difficult. It simply means hiring people who are reasonably smart, have some kind of investigative experience, have no axes to grind, aren’t frightened to ask difficult questions aren’t intimidated

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<sup>10</sup> IPCC is essentially the U.K.’s equivalent of the SIU, see Police Complaints in the United Kingdom on page 73.

easily, and can quickly learn to understand police culture, processes and the pressures of being a police officer – all while remaining objective. They should also possess good analytical skills and be able to write reports that are comprehensive, clear, cogent and comprehensible (which is a lot rarer than one might think).

Once you find these people, train them. Send them to police college, not just to learn about criminal investigative techniques but to get insight into police culture and attitudes. Partner them up with different lead investigators from both police and civilian backgrounds. Mentor, nurture and performance-manage. Expose them to as many different types of investigations as you can, as quickly as possible. Let them sit in on police and civilian witness interviews, then gradually let them participate. Train them in basic forensic science and motor vehicle collision reconstruction techniques – they do not have to become experts but they do have to know what is what. Teach them the technicalities of obtaining warrants. Send them on specialist investigation courses. Very soon, you will have civilian investigators who know far more about deaths and serious injuries involving police than the most hard-boiled Ontario homicide detective ever will.

Why? Because these new investigators will only ever deal with a limited number of situations, which will come up time and time again. In the main, they will arise out of shootings, arrests, mishaps while someone is being held in custody at a police station, operation of a police motor vehicle or sexual assaults. That's about it, with a few permutations.

It does not take civilians long to become expert investigators. What it does take is the oversight agency having the gumption, the resources and, above all, the will to put training civilians at the top of its priority list. It's a short learning curve, but it takes commitment to create the conditions where a civilian will climb it. And it should not just be about training civilians to be good investigators – it should include training them to be good investigative supervisors as well.

#### **4. RUN IT ON A SHOESTRING BUDGET**

The fourth principle of excellent investigation is that investigations must be sufficiently resourced. So, by extension, should an investigative agency. Starve an organization of resources and it will fail. Insufficient resources lead directly to inordinate delay and botched investigations, all of which erodes credibility.

That is what happened with the SIU. It rapidly gathered a reputation for incompetence based in large part on its slowness. In his review of the

criminal justice system, conducted in the wake of rioting in Toronto in 1992, former political party leader Stephen Lewis wrote:

I have heard incessantly, and critically, of the Special Investigations Unit. People have frequently called for the resignation of Mr. Justice Osler, who heads the Unit, and there is rarely a charitable word uttered about either its findings or its investigative capacity. ... The Special Investigations Unit has been underfunded from its inception 22 months ago... The unit must be permitted to achieve real credibility with both public and police – a credibility it does not have now. ... (I)t will take dollars and tenacity to assemble such a Unit (Lewis, 1992, pp. 8-9).<sup>11</sup>

Part of the problem was that the SIU was given a far broader mandate than the original task force had envisaged. Whether that was a result of the haste with which the legislation was thrown together is a matter of conjecture, but it is not clear if the drafters thought through the consequences. An arrest, a vehicle or foot pursuit, a motor vehicle collision – indeed any interaction between public and police whatsoever – if it resulted in a death or serious injury, SIU had carriage of it. If a man barricaded himself in a house and shot himself while the police surrounded it, that was an SIU investigation, at least until it could be established that police played no role in the death. The SIU’s mandate was not limited to deaths or serious injuries of civilians—it included cases where officers were involved in the death or injury of colleagues. One of the first major cases the SIU dealt with involved an officer who fatally shot another at a police shooting range.

Some of these investigations require massive resources. Fatal police shootings are homicides, albeit ones that may be justified in law. Homicides require resources. Think about all the things that have to be covered in the immediate aftermath of a police shooting. Let’s take a fairly routine example. A man driving a suspected stolen vehicle is shot by an officer in a residential street after a police chase and later dies after undergoing surgery in hospital. What does the SIU investigative team have to do? Here is just a partial list:

- Secure the scene;
- Protect evidence from the elements as necessary;
- Arrange for forensic examiners to attend the scene;
- Segregate and interview witness officers as soon as possible;

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<sup>11</sup> Mr. Lewis recommended that “skilled police criminal investigators of excellence” be seconded to the Unit. Thankfully, in my view, that never happened.

- Conduct a witness canvass;
- Segregate and interview civilian witnesses;
- Notify next of kin;
- Interview ambulance and fire department personnel who attended the scene;
- Deal with the media at the scene;
- Deal with the police union lawyers at the police station;
- Meet with subject officers, determine their condition and request immediate interviews;
- Attempt (usually without success) to persuade the subject officer's counsel that it is to the officer's advantage to be interviewed as soon as possible;
- Seize clothing and equipment, including firearms, from all involved officers, including those who did not discharge their weapons;
- Identify, secure and seize potential evidence at the hospital;
- Examine the suspect vehicle for anything that might have a bearing on what happened, including microscopic evidence, mechanical condition, etc.;
- Secure, search and examine police vehicles involved in the chase, including seizing any in-car camera tapes;
- Search the pursuit route and seize any available video of the pursuit;
- Arrange for the post mortem;
- Seize communication tapes, 911 records, police documentation;
- Obtain search warrants for items that cannot be obtained by consent (a hugely time-consuming process);
- Deal with any officer welfare or debriefing issues that may arise;
- Deal with support services and counsel for the deceased's family;
- Deal with the police chain of command;
- Keep the SIU chain of command and communications staff informed;
- Plead for more help.

The order of priority will depend on the circumstances, but most of these tasks have to be covered in the minutes or hours that follow the incident.

And that is just the beginning. Each task potentially raises its own challenges. Take, for example, what should be happening at the hospital. Investigators should get there as quickly as possible, on the basis that the best evidence is the freshest and it is all perishable to some degree – a tenet that applies to all aspects of virtually every SIU investigation. The investigators should search the ambulance the deceased was transported in.



They should retrace the route from ambulance to the operating theatre, again looking for physical evidence. They should ensure that the body is not washed, seize clothing and personal effects and note visible injuries. They should seize any blood samples in the hospital's possession – which usually means going through the onerous process of securing and sealing them and then obtaining a search warrant to seize them.

While the primary goal is to preserve physical evidence, the investigators should also interview ambulance personnel who were at the scene as quickly as possible, focusing on any utterances made by anyone, including the now-deceased and any police officer – particularly the officer who fired the fatal shot. They should speak to the surgeon and other medical people who had any contact with the deceased – not just to see if he made any dying utterances but also to get an initial idea of the nature and location of any wounds, particularly entry and exit ones, particularly if there may be a delay conducting the post mortem. The police officers who escorted the ambulance and stayed with the suspect are usually a mine of information. At the same time, investigators should speak to next-of-kin, who almost inevitably turn up at the hospital. They also have to speak to the Coroner to discuss time and location of the post mortem and the need to obtain hospital medical records.

This is by no means an exhaustive list. A lot depends on the circumstances of the incident. What if a police officer was injured in the incident in the same hospital? Cross-contamination becomes an issue. What if the man who was shot is not quite dead yet? Investigators have limited time to get his side of the story. They will move heaven and earth to get a dying declaration. Do they kick his mother out of the room as they do that?

Police forces routinely assign dozens of detectives and uniform officers to a homicide investigation. In one recent police shooting in Quebec, 30 to 35 officers were assigned to the investigation, according to the Sûreté du Québec. They have the resources. SIU did not.

*In its early days, SIU was often overwhelmed.*

October 31, 1991 – in the SIU's first year – was a busy but not untypical day. At 2:09 a.m., an “as-needed” (part-time) SIU investigator was getting his desperately needed but ultimately futile beauty sleep at home when the phone rang. It was one of the two full-time SIU employees, who advised him there had been a fatal pursuit involving a municipal police force east of Toronto, roughly 60 km from where the investigator lived. Two civilians had been killed, he was told. He was assigned as the lead investigator, which meant he got to make all the decisions in the field and to boss around his

team. Except there wasn't much of a team. The only other person who was available was another as-needed investigator who lived about 150 km away from the scene.

The lead investigator arrived at the scene at 3:58 a.m. His colleague arrived a little while later. By about 11 a.m., they had done what they could and were making their way back to SIU headquarters in downtown Toronto to fill in the reams of paperwork that are the bane of any investigator's life. At 11:31 am, the cellphone rang.<sup>12</sup> There had been a police shooting in an area about 40 km northwest of Toronto, about an hour previously. Could the lead investigator go but drop off his colleague at SIU en route, so she could continue to deal with the pursuit? Other investigators had been sent but they were both involved in an ongoing court case and could not stay. There was no one else available.

The lead investigator arrived at the shooting scene at 12:25 p.m. Earlier that day, a man had robbed a bank at gunpoint and driven off. Police caught up with him. The subsequent pursuit involved five different police forces and covered well over 100 km. The bandit had shot at police at various points during the chase. Several police officers from different forces had fired a total of 51 shots during the pursuit, though it wasn't clear at that time exactly who and where.

There was another exchange of gunfire when the suspect's vehicle stopped. He was arrested and found to have non-life-threatening gunshot wounds, though it was not immediately clear when and where he had sustained them. Three loaded firearms, as well as ammunition had been found in his vehicle when the pursuit ended, according to police. Once he was released from hospital, he would be charged with several very serious offences. No police officers had been injured.

The media were thick on the ground. The final shooting location was inundated by that most dangerous of phenomena – at least in the view of the street officer – senior officers equipped with radios and cellphones. Obviously, the police were investigating a whole bunch of crimes – the stolen car, bank robbery, shots fired at police – but the circumstances of the civilian being shot by police were entirely within the ambit of the SIU.

How many investigators would you need to investigate this thoroughly?

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<sup>12</sup> SIU had two cellphones, which at that time were about the size of a small bungalow. The red tape that investigators had to go through to get them would have made a robot weep.

When the SIU investigator begged for help, he was told that there was no one else immediately available. He was on his own until the following day. He did the best he could, eventually leaving the scene at about 7 p.m. En route back to the office, he was contacted by a police force about 100 km north of Toronto. A man had just died in one of their holding cells. They wanted SIU there ASAP. The investigator wasn't happy but, as he told himself, if you can't take a joke, don't join the job.

The fundamental problem was that SIU, at that point in time, only had two full-time staff and ten contract investigators.<sup>13</sup> The contract investigators weren't always available to respond, in some cases because the incident involved their former force or because they were tied up at with other matters, such as court cases or inquests.

Even the police recognized that the root cause of their complaints was about the SIU being slow and incompetent was that it was grossly understaffed for the task it had been set. In 1990-91, the total budget for the SIU was \$227,000. It investigated 21 firearms deaths and injuries, 7 custody deaths and 5 deaths involving the operation of a police vehicle (pursuits or collisions).

In 2004-05, the unit investigated a similar number of incidents – 12 firearms deaths or injuries, 15 custody deaths and 9 vehicle-related deaths. Its budget was approximately \$5.5 million. It had 11 full-time, 25-plus “as-needed” and 12 full- and part-time forensic investigators.

By comparison, the 2010 operating budget for the Toronto Police Service alone is \$892.2 million.

Even when the SIU's budget was increased to just over \$2 million in 1993 after Stephen Lewis' report, the demands for service went far beyond what that paltry sum could cover. On September 29, 1994, a 41-year-old mentally ill man of Grenadian origin who had a significant crack habit was shot and killed in his rooming house in downtown Toronto. There were two officers present at the time; one of whom had been hit with a hammer by the man and sustained a serious head wound.

The shooting happened at about 6:15 p.m. The SIU was informed at 6:55 p.m. Although there were now five full-time investigators and two managers at this point, along with roughly ten as-needed personnel, there was only one SIU investigator available to respond to the call. This was due

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<sup>13</sup> Some of the original hires had fallen by the wayside, in some cases because of the uncertainties of the amount of work they would receive.

to other ongoing investigations, the prohibition on investigating one's former force, vacation and a host of other reasons. The SIU investigator assigned to the case was already carrying a hefty caseload, including over a dozen shootings, sexual assaults and custody deaths.

The investigator arrived at the scene at 8 p.m. He called his supervisor and briefed him. The supervisor gave him the option of simply walking away and calling in another police force to take over the investigation. Tempting, but that could have been the last fatal blow to the credibility of an organization that was teetering on the edge.

This was a case that fit squarely into why SIU had been created – to ensure an impartial, no-stone-left-unturned investigation in high-profile cases. The incident pressed a lot of buttons – race, mental illness, two officers against one suspect (which inevitably raised such questions from armchair quarterbacks as, “Why couldn't they overpower him?” or “Why didn't they just shoot him in the leg?”). As well, SIU was going through a blaze of publicity related to its mandate and developing a new standard operating procedure to govern interaction with police.

Luckily the scene was indoors. It was relatively easy to secure and protect from the elements and the investigator was able to obtain forensic assistance from an outside police force. That was crucial, as physical evidence such as blood spatter and the location and angle of bullet holes was key to establishing what had happened.

*Closely allied with the resource issue is the contention that civilian oversight agencies are just a big waste of taxpayer's money.*

If patriotism is the last refuge of the scoundrel, then cost is the last refuge of those who oppose effective police oversight. Civilian oversight agencies are wasteful bureaucracies, say the naysayers. They will cost the taxpayers millions of dollars – money that could be far better spent protecting the innocent from scumbag criminals. Why, they suggest, we could buy a helicopter, fund a musical ride, or dry-clean a lot of uniforms with the money wasted on overseeing police.

Those who take this position ignore the fact that investigations cost money, regardless of who does them, especially if they are done properly. If police forces transferred all the cash they spent investigating themselves to an independent civilian agency, civilian oversight of police could be well nigh cost-neutral. And the existence of a civilian agency frees up officers to fight crime on the streets, into the bargain.

However, danger lies in too big or too small a mandate. The agency needs a broad enough mandate to justify full-time staff and guarantee an immediate response in sufficient numbers. But too narrow a mandate may result in lavishly paid public servants twiddling their thumbs, waiting for the bell to ring.

The key is to tailor the mandate of the oversight agency accordingly. Examine past history. Assess what the patterns are and what you need. How many incidents are you likely to deal with if the mandate is framed in a certain way? You may want to include off-duty incidents or investigating allegations of crimes that do not involve death or serious injury. Could the agency take the lead in conducting coroner's investigations in cases that fall within the mandate, a job normally done by police?<sup>14</sup>

## **5. UNDERESTIMATE THE RESISTANCE YOU WILL FACE**

Evidence given by Wiche and other police witnesses at trial that they believed the SIU to be incompetent and incapable of carrying out a fair investigation must be given little weight. The witnesses fail to cite any examples of negligent or incompetent behaviour on the part of SIU or any basis on which their opinions were formed. There appears to be, on the part of certain police witnesses and certain police associations, an almost Pavlovian reaction against a civilian agency investigating the conduct of police officers in carrying out their duties and against the idea that such an agency could conduct an investigation which would be fair to police officers. This is particularly surprising when the statistics given in evidence establish that in 97% of cases, the investigation exonerates the subject police officer (Ground, J. in *Wiche v. Ontario*, 2001, at para. 61).

No book on police oversight is complete without this extract from Mr. Justice Ground's judgment in the case of *Wiche v. Ontario* (2001). The case involved a police officer (Detective Wiche) who unsuccessfully sued the SIU and its then Director, André Marin, for \$30 million, claiming he was the victim of malicious prosecution and a negligent investigation.

The incident that gave rise to the court case was a police shooting that occurred in June 1996. Detective Wiche shot and killed a 16-year-old boy who was driving a stolen car. After the investigation, the SIU Director determined he had reasonable and probable grounds to charge Wiche with

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<sup>14</sup> In Ontario, Coroner's inquests are mandatory when someone dies in police custody. SIU does the criminal investigation, then hands over the file to a police agency that investigates issues germane to the inquest, on behalf of the coroner. On the face of it, it is expensive duplication.

manslaughter. He was discharged at the preliminary hearing, during which Wiche was stabbed by the deceased's brother. Thankfully, he survived. The civil trial began in November 2000 and heard 34 days of evidence, over the course of nearly four months. As the lead investigator for much of the investigation, I spent five fun-filled days in the witness box.

What Justice Ground suggests, at least to my legally untrained mind, is that the police objected not just to what the SIU had done in this case, but to the fact that there was an SIU at all. He also seems to say that if you peel away the hysteria, there is no reason for police to fear oversight.

Another story illustrates the point: In the SIU's early days, the Director was invited to present to a class of about 30 or so Detective Constables and Detective Sergeants at a largish police force. He picked one of his investigators, who was not swift enough to escape in time, to accompany him. The investigator had been a police officer only a few years ago in the U.K. and, naively, thought that there might still be a connection between him and the officers in the audience. How spectacularly wrong he was.

The Director, a reasonable chap and former Crown Attorney who had worked closely with police to put some very bad guys in jail, presented about SIU, focusing on the reasons why it had been created. The reaction from the police in attendance was visceral:

- “Why are police always the ones who are picked on for oversight?”
- “Why are we all assumed to be racists?”
- “Why are we all assumed to be thugs?”
- “Why can't we be trusted to investigate ourselves?”
- “You are just a bunch of politically motivated lefties.”
- “You are appeasers and apologists for special interests who are out to get police officers.”
- “What right do you have to second guess us?”
- “Your investigations take far too long – good officers are left dangling.”
- “You guys are a bunch of amateurs.”
- “The civilians amongst you don't have a clue what they are doing and have never walked in our shoes.”
- “Why should my career, my livelihood and maybe my liberty be in your hands?”

Legitimate questions. Some of the comments had a basis in fact – particularly the ones about lack of resources. It was clear that the officers were genuinely aggrieved.

The atmosphere became increasingly heated and personal. Voices were raised and fingers pointed. Until one gentleman at the back of the room stood up. He pointed at the ex-police officer from the U.K. who had gone over to the dark side and, in a very loud voice, said: “You can’t investigate me, because you are an immigrant...”

At which point the room went deathly silent.

One of the detectives at the front stood up. He had been one of the most vocal participants. Articulate, reasoned and passionate, he had posed particularly incisive questions. I think he truly believed that the SIU was a travesty – not necessarily because of oversight itself, but because it was being done in a way he perceived was simply not fair to police officers.

He turned around, pointed at his colleague and said, firmly and clearly: “You fucking idiot. You have just undermined everything we were saying to these guys. SIT DOWN!”

Resistance to civilian oversight takes many forms. It can be strategic; for instance police special interest groups – be they chiefs, middle managers or unions – lobbying politicians to abolish you or, worse, have serving police officers seconded to your agency. Or working to persuade the public that the agency is not worth the expense. It can be tactical – refusing co-operate, neglecting to notify you of incidents that fall within your mandate in a timely fashion, obstructing access to police officers involved in incidents, delaying providing documents. It might even be passive – perhaps letting police unions control the investigative process.

The solution? All you can do, if behind-the-scenes suasion fails, is to demonstrate your value to the police, as well as the politicians and the public. Educate all levels of police about the value oversight brings to their work. Effective oversight works in their favour. Sure, if oversight is done properly, they lose control of the investigation – but the benefits are huge. It takes the onus and the focus off of them. It protects them from allegations of protecting their own. Above all, effective oversight boosts public confidence in the police, which is a good thing for everyone. It was the SIU that took the heat from families and community groups when it exonerated officers, as they did in over 97 per cent of cases investigated, as Justice Ground noted. If that is a witch-hunt, put in place by commie cop-haters, then it is a stunningly unsuccessful one.

### **Create a culture of conciliation and consensus**

The goal of any oversight agency is to be respected by all its constituents. A certain level of friction between the overseen and the overseers is normally

a sign that the system is working. That is true in the oversight business generally, and acutely true in the world of police oversight.

A natural reaction to being unpopular and unwanted is to try to make friends with those who do not like you. There may be a temptation to compromise, to bend a little, to meet halfway, to debate and discuss. In the early 1990s, the SIU did try to meet police halfway in some areas. Mainly it was because it had so few resources to cover so many bases that it had no option. So it made concessions. Here are a few:

#### *Attendance at post mortems*

In its early days, SIU allowed police officers from the force under investigation to attend post mortem examinations of individuals who had died after coming into contact with police. A post mortem is a potentially rich source of information that may prove very useful as investigators interview those involved in the incident. For example, the nature and location of abrasions, lacerations and contusions, the track a

bullet has taken through the body, which bones were broken, entry and exit wounds, even what is found in or on the person's clothing as it is removed at the beginning of the autopsy – all of this is potentially vital evidence that the investigator has knowledge of, but, at least ideally, other parties do not.

Consider a typical police custody death. A man is arrested for an assault. He shows no sign of any injury. He's brought to the local police station and put in a cell, on his own. At some point later he is found with vital signs absent and an ambulance is called. He is pronounced dead at the hospital. A post mortem is scheduled for the following day. The post mortem finds no anatomical cause of death. There is some bruising, but nothing that had any direct bearing on his cause of death.

At this point, none of the officers who had had contact with the prisoner during his time in custody have been interviewed. Yet, according to early SIU practice, members of their force were present at the autopsy and made privy to potentially vital information. Astounding. What possible reason is there for an officer from the involved police service to attend the post mortem? Who are they going to prosecute for the assault? No one else is involved. There is no evidence that the dead guy was assaulted prior to being arrested. What legitimate interest do they have in the evidence gathered? None, in my view.

The counter-argument at the time, at least as far as I understood it, was this: What if there is a disciplinary issue that is the responsibility of the police,



not SIU? Just in case a crime has been committed that somehow falls outside of SIU's mandate, police should go to all post mortems!

Poppycock. First, the police were always given access to the post mortem report once the SIU investigation was complete. Second, if a police force furnished a valid reason to attend the autopsy, then that could be assessed by the SIU on a case-by-case basis.

The precedent was established from the beginning that police could just turn up at a post mortem whenever they felt like it. They should have been thrown out.<sup>15</sup>

### *Joint Interviews*

Worse, in the early days, police and SIU investigators would conduct interviews of witnesses – including police officers – together. This was not only allowed but encouraged. Think about it. How forthcoming are you going to be if you are a civilian or police witness, particularly if there are things that you would rather the Chief or police in general didn't know about? The optics were, yet again, execrable. In one instance in 1991, an officer had shot a young black man in the back after the man stole a purse. The officer agreed to be interviewed under caution, within hours of the incident. The SIU lead investigator allowed a homicide detective from the officer's force to be present during the interview, in spite of vociferous but futile objections from the SIU investigator conducting the interview. The detective was allowed to ask questions. How "independent" a "civilian" investigation was that?

### *Points of Contact*

Be very careful when police forces use words like "liaison person" and "points of contact" in their dealings with your oversight agency.

"Oh, it will help us get information to you more quickly," they would say. "We can co-ordinate, assist, expedite, facilitate." In some instances, that was indeed the case. In many others it wasn't. A Detective Inspector from a mid-size municipal police force was discussing "SIU liaison" with a SIU investigator in late 1993. The force had just created a team whose mandate was, he claimed, to "liaise with and assist the SIU when they are called, to

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<sup>15</sup> In Ontario, it is the coroner who decides who attends a post mortem. The SIU did not negotiate with the coroner to exclude police officers in the early days. It was not until André Marin was appointed SIU Director in 1996 that he worked with the coroner to banish officers in appropriate cases.

ensure the investigation is done as expeditiously and efficiently as possible.” With a conspiratorial wink and a huge smirk, he added: “Of course, it’s really to keep the Chief informed of the progress of the SIU investigation and what they are up to.”

Fair enough. It works for the police. But why should a police oversight agency accede to playing by their rules? Do not fetter yourself by agreeing to deal exclusively with a “liaison” – unless you decide that, at that particular time, in those particular circumstances, it works for you. It is your investigation. Act that way.

### *Auditing*

Perhaps the ultimate humiliation for the early SIU was when it allowed itself to be audited by two middle-ranking police officers.

To nobody’s great surprise, the auditors’ findings were less than complimentary. It was very clear that it was the product of two police officers who went out and asked a group of other police officers what they thought of the SIU. By this time, SIU had investigated 57 police shootings and 32 custody deaths. To my knowledge, the “auditors” had nothing even remotely close in terms of experience – and nor should they. They came from two Ontario police forces, one a relatively small one. Shootings and custody deaths were huge events for them, happening once in a blue moon. The chances that either of them would ever be directly involved in a police death or serious injury investigation was minimal. For us at the SIU, of course, they happened almost every day.

The audit team came up with a bunch of recommendations, most of which were, at least in my view, designed to take away control of investigations away from the SIU and put it back firmly in the hands of police. Oversight agencies should be audited, of course. The SIU certainly had significant weaknesses that begged for practical solutions. But if you are going to have an audit, make sure it is conducted by someone who is truly a neutral observer.

## **7. Judge it on its charge and/or conviction rates**

The SIU’s charge and conviction rates were, and are, abysmally low. But that is not the measure of the success of a police oversight agency.

The point of the SIU is not to charge or convict police officers. It is an *investigative* agency. Its goal is to conduct thorough and impartial investigations into incidents that fall within its mandate. That, and that alone, is the test by which it should be judged.

## **8. Allow ever-changing leadership**

Between September 1990 and September 1996, the SIU had nine different Directors or acting Directors. Investigators who were there throughout this period watched in stunned amazement as they came and went. Some quit, one was fired, some were overwhelmed by the job, some were practically dragged into the office, and some saw their role as temporary caretaker.

That is not to say that they were in any way deficient – most were conscientious, talented and very hard working. But few seemed to have any idea of the pressures of the job, the constant sniping from all quarters, the media scrutiny and the sense of isolation and loneliness that came with it.

This rapid succession of Directors obviously created problems. It was a steep learning curve for most of them, though virtually all were seconded Crown Attorneys who had excellent knowledge of the criminal justice system. However, few had any experience leading teams or managing investigators. Few had worked in unionized environments or spent much time in the public spotlight.

More importantly perhaps, the revolving door added to the perception of instability and impermanence that had begun to cloud the SIU. It needed stable leadership.

## **9. Let cases fester**

Delay is the mortal enemy of an oversight agency. The SIU rapidly acquired a reputation for taking forever to complete investigations, which fed into perceptions of incompetence. That created a lot of adverse media comment and a lot of resentment from police and families – much of it justified, at least in my view. How did it happen?

SIU investigations have two stages. First is the fact-finding process. The second is the review of the evidence by the Director.

Much depends on the circumstances of a given incident, of course, but the fact-finding is a fairly standard process. In most cases securing and processing the scene(s) was job one, seizing other physical evidence a close second, locating and interviewing police and civilian witnesses next, and then gathering all the relevant documents. If you had enough investigators, all of these things could be done almost at once.

There were four common reasons for delays at this stage.

1. Forensic examination of physical evidence. This can take time, particularly if toxicology tests are required.

2. Witnesses not being available for interview. Some civilian witnesses could be difficult to track down, especially those in the criminal fraternity (not a rarity in SIU cases). Interviews with witness officers were delayed by officers' work shifts and sometimes by the availability of police union lawyers.
3. Subject officers declining to co-operate. This could leave the investigation in limbo. In one case, two officers confronted a suspect in, believe it or not, a dark alley. Both officers opened fire. The suspect was killed. A non-police-issue firearm was found at the scene, close to the dead man. There were no witnesses. It was not possible to ascertain forensically who had fired the round that caused the fatal wound. Accordingly both officers were designated subject officers and both availed themselves of their right, under the SIU protocol, not to be interviewed by SIU investigators. The key issue in these investigations tends to be what was going through the officer's mind when the incident occurred. The only person who knows that for certain is the officer. No other evidence emerged that was directly relevant to determining if the officers' decision to use lethal force was justified in law. Result: Not enough evidence to charge either officer; not enough evidence to exonerate. Impasse.
4. Simply not enough SIU investigators to go around.

How to minimize delay? Front-end load your investigation – get all hands on deck and get the evidence gathered ASAP. This is what the police do when they investigate serious incidents. Once that initial phase is over, assess what else you need. Do you really need that piece of forensic evidence to determine whether or not to lay a charge? Why wait for three months for test results to come back if there are ten independent witnesses who saw the armed suspect charge the officer, leaving the officer no option other than to shoot? Use your powers to insist that the witness officer is brought back on duty. If the lawyer of choice can be there, so be it. If not, get another one. (Ontario has a shortage of many things, but police association counsel was not one of them, at least in my day.) Prioritize the high-profile, high public interest incidents and put as many investigators as you can on those cases, to get them completed. Or focus on those where there is significant evidence that an officer has committed an offence. Or where it is absolutely clear almost from the outset that there is no criminality on the part of officers. Identify the cases that can be fast-tracked and get them out the door.

Don't overcomplicate the process. Not every single case needs to be a gold-plated Cadillac of an investigation. In fact, one of the main reasons for inordinate delays in the early days of the SIU was the insistence that virtually all high-profile cases had to be presented to the Director in a format that closely resembled a submission to the Court of Appeal. The "brief" (which was usually anything but) had to be meticulously indexed and formatted, with all witness evidence summarized and cross-referenced to pieces of evidence. The briefs looked beautiful. They could be hundreds – sometimes thousands – of pages long. But they took forever to put together. Investigators – who tend to prefer investigating to writing – put off assembling these briefs until the very last moment, which led to further delay.

The second phase of the SIU process was the Director's review of the evidence and decision on whether or not there were reasonable and probable grounds to believe that a police officer had committed a criminal offence. It is an onerous job. Whatever the result, someone was going to be unhappy. It seemed that whenever an officer was charged, it would be deemed a "politically motivated decision" by some in the police community, but whenever one was exonerated, other special-interest groups would complain the SIU was "kowtowing to the police."

Nevertheless, it was important to make that call as quickly as was practical. The delays in making decisions were at the root of much of the criticism of SIU. Being investigated is no fun and it is not fair to officers to have the possibility of being charged criminally hanging over their heads for inordinate lengths of time, particularly as these are not difficult investigations when everyone co-operates. Nor is it fair to the family members of those killed by police to be kept on tenterhooks.

The early SIU failed miserably in this respect on far too many occasions. It was not through bad faith or relishing watching officers or families dangle in the wind. Rather it was a lack of resources and then, on occasion, a seeming inability to make a decision within a reasonable period. Reasons advanced to justify delays included the need to seek advice on complex legal issues and the fact that the Director – who was required to adjudicate on every single case – was also grossly overworked. The latter had some merit – one person had to, in theory, review every single piece of evidence generated by a case, which could run to several thousand pages in major incidents. In some cases, it took months – or even years – to render a decision. A police officer sued SIU for the delay in his case. It had taken the Director fourteen months to conclude that there were no grounds to lay a charge in what seemed to be a straightforward shooting. The officer may have had a point, because the Crown settled.

## 10. Prevent it from demonstrating its value

“Police Watchdog Called Politically Motivated,” read the banner headline on the front page of the *London Free Press*, in August 1993, referring to comments made at a police association conference. “We have an (SIU) whose one goal in life is to convict our officers. To me, that is pretty scary,” a senior police union official was quoted as saying. A police chief told the assembled masses: “Police forces have to be accountable ... but the body doing the investigation has to have some integrity and not flounder around as (SIU) has been doing.”

Fair comment? Perhaps. But there was certainly another side to the story, at least from the perspective of the investigators employed by the SIU. In reality, it was doing a fantastic job. The mere fact that an independent body was now investigating police shootings – particularly those where ethnic minorities were involved – had infused credibility into the investigative process. On the ground, the fact-finding process had mostly been removed from the hands of the police. The investigations still took way, way too long, but the quality of most was never questioned – in fact, many were praised by lawyers who reviewed them.

Creating an independent police oversight agency is, when one actually thinks about it, a good news story for all concerned. The problem was that no one was telling the world what value SIU brought to the table. It would issue a press release here and there, and Directors would grant interviews on rare occasions, but the general approach was to avoid the media. The SIU acquired a reputation for opaqueness and secrecy. It hid behind the *Freedom of Information and Protection of Privacy Act*, looking for ways to block access to its investigations, rather than embracing openness and transparency, at least in my (and some of my fellow investigators’) view.

There was little in the way of targeted, intelligent use of the media to educate the public about what SIU did and how it did it. It was a timid, defensive approach that left journalists who might have been sympathetic to get their “facts” from other places, such as the ubiquitous “police sources.” The nadir came when an SIU spokesperson burst into tears at a press briefing, apparently because some reporters’ questions were too pointed. Not exactly the SIU’s finest moment.

The importance of demonstrating the unit’s value was made starkly apparent when André Marin was appointed Director in September 1996. He instituted changes in the way the SIU worked, including imposing a 30-day deadline to complete investigations. That instantly neutralized one of the few genuine criticisms police had of the unit.

Then he went out and told the world what SIU was doing. He not only engaged the media, he encouraged them. He had open days at the office, broadcast live on breakfast TV. He met with the editorial boards of major newspapers across the province. He arranged for a journalist with a major Toronto newspaper to shadow investigators as they investigated a very high-profile police shooting. The resulting articles sent some in the police community apoplectic, even though many police forces did “ride-alongs” with journalists themselves. The response from the public was very positive. They saw how a contentious shooting was investigated, how the evidence was gathered and exactly how the decision whether or not to charge a police officer with an offence was made (Toronto Sun, 1997). That kind of transparency went a long, long way to counter accusations that SIU was incompetent, ineffective or, with its 97% exoneration rate, a creature of the police.

Marin was also not shy about letting the world know when police, in his view, were not co-operating, which caused consternation within certain segments of the police world. If he thought that police should be thrown out of post mortems where they had no business being, or witness officers were dragging their feet in agreeing to interviews, he said so in the media. It was an approach that, while taking him off more than a few Christmas card lists, got the SIU the all-important respect it needed to survive. It also led directly, in 1997, to the government hiring a retired judge to conduct a review of the SIU that, in turn, led to regulations designed to improve the effectiveness of its investigations. They were not perfect, but they were certainly an improvement, albeit hundreds of investigations and eight years late (Regulation 673/98 *Police Services Act* of Ontario).

## **Conclusion**

The SIU has made considerable progress since the dark days of the early 1990s, against tremendous odds. While it is far from perfect, it is moving in the right direction, as André Marin points out in *The Ontario Special Investigations Unit: Securing Independence and Impartiality* on page 101. Many of its imperfections have their roots in what happened when it was created.

That said, I suspect my grave will be knee-deep in meadow grass before police embrace oversight unequivocally, or before certain sections of the community think that police oversight agencies are free from a pro-police bias. And, unless the process is transparently fair, fast and thorough, why should they? Police officers under scrutiny deserve the best, quickest investigation possible, as do those they are alleged to have killed or seriously injured. So does the average citizen, who pays the bills.

So, if you are going to create a police oversight agency, do it properly. Make its mandate and limitations clear. Give it what it needs to fulfill that mandate. Support it in the face of inevitable criticism. Don't create expectations that will never be met. If you are frightened of upsetting special interest groups – including the police – then don't bother. Don't compromise investigative integrity for expediency's sake. Don't be afraid to demonstrate your value. If you don't, you will be perceived as impotent and/or incompetent. Your agency will wither and die. And nobody will care when it goes, because it will have met the self-fulfilling – but totally inaccurate – prophecy that civilians simply can't investigate police.



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# **Policing the Police in Canada: Alternative Approaches to the Investigation of Serious Police Wrongdoing**

David MacAlister

## **Introduction**

Over the past 20 years, the need for an effective system for dealing with serious complaints regarding alleged police misconduct has been a legitimate concern in Canada and elsewhere. A number of high-profile police-involved deaths, including death-in-custody cases, and allegations of differential treatment of racial minorities, have brought forward concern over whether it is still tolerable to allow police to investigate themselves. Calls for reform have grown out of the inherent dangers in allowing the police to investigate themselves, where the concerns over a perceived lack of objectivity and legitimacy have severely hindered public confidence in policing. The questionable practice of police investigating police has led to grave public mistrust of the police and a widespread lack of confidence in the entire complaints system.

Historically, the police in Canada have investigated themselves. The investigation of allegations of wrongdoing has typically been conducted by Internal Affairs or Professional Standards units within the police force directly involved in the alleged wrongdoing. In high profile or extremely serious cases, the investigation was usually carried out by major/serious crime detectives within the same police organization that the alleged wrongdoing occurred. This process still prevails among all municipal police agencies in Quebec, New Brunswick, Newfoundland & Labrador, and Prince Edward Island, and in those jurisdictions using the Royal Canadian Mounted Police (RCMP) where an outside agency is unwilling or unable to investigate the force.<sup>1</sup> Three jurisdictions, British Columbia, Manitoba and Nova Scotia, are in the process of modifying their approach to investigating these alleged wrongs. The RCMP, which does a considerable amount of local policing across the nation under contract, only recently allowed for

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<sup>1</sup> This includes New Brunswick, Newfoundland and Prince Edward Island, where the RCMP do a considerable amount of local or provincial policing under contract, and the three territories where the RCMP is the only police agency.

external investigation of their police-involved deaths and serious injuries.<sup>2</sup> While several jurisdictions remain steadfast in their use of internal processes to investigate allegations of serious police wrongdoing, others have taken the bold step to move towards increased accountability via the use of an independent agency to conduct these investigations. Only Ontario has had a genuine external agency responsible for investigating serious allegations of police wrongdoing, while Saskatchewan and Alberta have each made some effort to provide external agencies for these investigations. However, considerable variability in the nature and scope of these agencies prevails.

In an attempt to restore public confidence in the police, various alternative approaches have been employed in different jurisdictions around the world in an effort to make the police appear to be accountable and transparent. These systems vary from jurisdiction to jurisdiction, and do not conform to a single model. Each has varying degrees of external involvement and oversight. A key element of these models is a process by which allegations of serious police wrongdoing are investigated by an agency independent of the one to which the alleged malfeasant police officer belongs. In theory, each of these processes is intended to provide effective, independent investigation. However, in practice, this does not always appear to be the case. A major criticism of some of these newly adopted investigation systems is their lack of independence from the police. Many jurisdictions continue to use seconded and/or former and/or retired police to conduct investigations of alleged police wrongdoing. It is believed that the use of police or former police ensures the best investigative practices are used. In actuality, this practice still results in police investigating police, with a concomitant appearance of ongoing bias denying the public a sense of genuine objectivity in such a process. Although police have been investigating themselves in many jurisdictions for many years, alternatives to this practice need to be fully explored.

Over the past ten years, and particularly in the last five, the image and reputation of the police in Canada has been tarnished. Trying to regain public trust and confidence in the police is not an easy task, but allowing the police to investigate themselves has apparently had adverse effects. The trust of the public can only be restored and preserved if the police complaints process is conducted by an independent third party. This

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<sup>2</sup> This occurs in those jurisdictions where an independent entity has been established to investigate deaths and serious wrongdoings by the police. See: RCMP Announces New Policy on External Investigations. February 4, 2010. Online Press Release: [www.rcmp-grc.gc.ca/news-nouvelles/2010/02-04-external-externe-eng.htm](http://www.rcmp-grc.gc.ca/news-nouvelles/2010/02-04-external-externe-eng.htm)

requires a civilian led agency, where there is not only civilian oversight, but more importantly, a civilian-managed and civilian run process.

Ontario became the first jurisdiction in Canada to adopt an independent civilian oversight agency responsible for conducting criminal investigations of alleged police wrongdoing (Marin, 2008, p. 8). Until very recently, Ontario remained the only Canadian jurisdiction employing a genuine civilian investigative agency for these purposes; however, it has recently been joined by Saskatchewan which has bought into the civilian investigation model on a lesser scale than Ontario, and Alberta which has very recently adopted a civilian-led external investigation agency. New investigation agencies are on the horizon in Manitoba, B.C., and Nova Scotia. Despite what appears to be the promise of progressive developments in this area, the reality is that many of these reforms appear to be inadequate and unable to achieve true independence and accountability.

### **The Flagship of External Investigation?: Ontario's Special Investigations Unit (SIU)**

Ontario was the first Canadian province to develop and implement an independent oversight body in handling police investigations with the creation of the SIU in 1990. This independent, civilian-led agency is responsible for conducting criminal investigations involving serious injury or death allegedly committed by persons serving with the municipal and provincial police (*Police Services Act*, 1990, s. 113(5)).<sup>3</sup> This includes the authority to investigate allegations of sexual assault. The SIU has full powers and authority to investigate, and where the evidence warrants, the Director of the SIU may charge officers with a criminal offence (s. 113(7)). However, in the majority of cases, there is no evidence of criminal activity and no charges are laid. It is noteworthy that the SIU's primary role is to conduct an independent, thorough, and impartial investigation, assuring the public that the conduct of police is not excused and is subject to careful examination. The SIU's powers, responsibilities and duties are set out in s. 113 of the Ontario *Police Services Act* of 1990.

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<sup>3</sup> In Ontario, many municipalities provide their own policing, while the Ontario Provincial Police provides services to all rural parts of the province and those communities which choose to use them under contract. The RCMP has a very limited role in the province, largely confined to federal (non-*Criminal Code*) enforcement and policing Parliament Hill. As a consequence, the SIU has jurisdiction over the vast majority of police-involved injuries and deaths arising in that province.

Subsection 113(9) of the Ontario *Police Services Act* addresses the duty of members of police forces to co-operate with SIU investigations. It states that “[m]embers of police forces shall cooperate fully with the members of the unit in the conduct of investigations.” However, this has been a source of contention for the SIU since the onset. There have been issues of disagreement between the police and the SIU in respect to the “duty to cooperate” (Scott, 2009).

The SIU reports to the Ministry of the Attorney General, but its investigations and decisions are independent of both government and the police. In an effort to promote SIU’s independence, the *Police Services Act* prohibits police officers or former police officers from assuming the position of Director (s. 113(3)). In addition, the Act does not allow any “serving” police officer to be appointed as an SIU investigator (s. 113(3)). However, the SIU does allow for the use of “former” police officers as investigators, including former RCMP officers and former police officers from other jurisdictions such as England. Former CSIS investigators are used as well. The Act does not allow investigators to participate in any investigations that relate to the police force that once employed them (s. 113(6)). This is “strictly enforced” to ensure that former police officers do not investigate police officers they know (Scott, 2009).

The SIU consists of a Director, who is appointed by cabinet, as well as civilian investigators, who are appointed under the *Public Service Act*. The SIU is led by the current Director Ian Scott, a lawyer who has practised exclusively in the areas of criminal and administrative law. The SIU employs a total of 80 people including 40 full-time staff, 14 full-time investigators (7 with a policing background and 7 non-police investigators), and 40 as-needed officers, mainly consisting of retired police (Scott, 2009). The investigative staff includes individuals who are experts in traffic accident investigations and collision reconstruction (SIU Website). The SIU also has its own in-house Forensic Identification Section, with the ability to assist in all Forensic Identification work. This team is led by 2 full-time Forensic Identification Supervisors, and 10 as-needed forensic identification technicians.

Any incident involving serious injury or death must be reported to SIU by the police service involved; however, it may also be reported to them by anyone else. If the incident raises any questions or doubts regarding the SIU’s jurisdiction, a review of the reported facts is conducted. If this process confirms the SIU’s jurisdiction, it launches a full-scale investigation. If there continues to be a problem with jurisdiction, the Director is consulted and may use his/her discretion to terminate any inquiries.

An important matter impacting on jurisdiction is determining whether the facts of a situation have resulted in a “serious injury.” This term is not defined in the Police Services Act, so its meaning was ironed out in meetings between the initial SIU Director and senior police managers in the province (Scott, 2009). Justice John Osler, as Director of the SIU, settled on the following working definition:

“Serious injuries” shall include those that are likely to interfere with the health or comfort of the victim and are more than merely transient or trifling in nature and will include serious injury resulting from sexual assault.

“Serious injury” shall initially be presumed when the victim is admitted to hospital, suffers a fracture to a limb, rib or vertebrae or to the skull, suffers burns to a major portion of the body or loses any portion of the body or suffers loss of vision or hearing, or alleges sexual assault. Where a prolonged delay is likely before the seriousness of the injury can be assessed, the Unit should be notified so that it can monitor the situation and decide on the extent of its involvement.

Even this definition is subject to varying interpretation. Some incidents that appear to have been very serious, including shootings by police, beatings leaving the victim black and blue, and an injury resulting in the loss of a dozen teeth, have been determined not to fall within the SIU’s jurisdiction.

Following an independent investigation by the SIU, if the evidence supports the claim that a criminal offense was committed by a person(s) serving with the police, the Director can cause a charge to be laid and a public trial will be held. On the other hand, if the evidence does not support the claim that a criminal offence was committed, the investigative file will be closed.

Some recent statistics are noteworthy. According to the current Director, Ian Scott, police occurrences warranting SIU investigation have increased every year since the SIU was created in 1990, and have doubled since the early 2000s. For the 2009 year, there was a 15% increase in the number of cases over the previous year. In-custody cases are the most common occurrences. In 2009, there were 257 occurrences investigated by the SIU resulting in nine charges being laid.

### **Evaluation of SIU**

Prior to the establishment of the SIU, cases resulting in serious injury or death involving police in Ontario were investigated by police. This pre-SIU system represented the traditional model of investigating police wrong-

doing, without oversight wherein the police were totally autonomous, handling criminal investigations of their own officers internally. However, in 1990, with the advent of the SIU, a new model of police oversight was introduced. The SIU offered a very promising change in that it had specific safeguards in place to maintain the legitimacy and impartiality of the oversight body.

In 2008, the Ontario Ombudsman looked into the Ontario Special Investigations Unit's operational effectiveness and credibility, producing reports entitled *Oversight Unseen* (Marin, 2008; Marin, 2011). The SIU a civilian agency responsible for investigating allegations of wrongdoing involving serious injury and death caused by police officers in that province. Created in the early 1990s, concern had been expressed that the agency lacked credibility and was ineffective in performing its investigative function.

The first report complements Ontario for moving to the forefront by being the first Canadian jurisdiction to use a civilian investigation agency. However, numerous problems were identified. Public perception of the SIU was that it had the image of being a “toothless tiger and muzzled watchdog” (Marin, 2008: 74). This had resulted in numerous complaints about the operation of the unit.

The independence of the agency was called into question by Marin's initial report, particularly in light of the continuing links brought about by former police officers being employed as investigators in the unit. The result is a public perception of a pro-police bias. The internal culture of the SIU was adversely affected by the use of former officers who sometimes showed their affinity towards the police by wearing pins on their lapel identifying their former police employer. Some SIU investigators were reluctant to insist on cooperation from forces being investigated. The lack of cooperation from police agencies has been an ongoing problem since the inception of the SIU; police often refuse to cooperate with SIU investigators. Delay by the police in notifying the SIU of cases requiring SIU involvement were compounded by delays in getting to incident scenes and further delay in interviewing witnesses brought about by the lack of staffing. Decisions made by the SIU not to charge police officers are not subject to explanation in a public venue which provides a further cause for concern. A significant problem identified in the report was the deference given to the police during the investigations.

Mr. Marin concluded with a list of 45 recommendations for reform. These included aggressively pursuing reasons for non-cooperation. The SIU was also told it should take active steps to minimize delay. It should seek to



diversify its staff, and distance itself from connections to the police. Changes to legislation were recommended in order to enhance the mandate and legislative authority of the SIU.

While the SIU may not represent an ideal model of police oversight, it has made some significant progress that should not be ignored. The SIU is a civilian-led agency with no serving police officers employed by the organization. Unlike other jurisdictions, the SIU is actually prohibited from using seconded police. Also, no former police officers may assume the position of Director. It also prohibits any former police officers from investigating the agency for which they used to work. However, the SIU does employ “former” (in some cases retired) police as investigators. While it may be argued that using “former” police still results in police investigating police, there is a fundamental difference between using “former” police officers and using “seconded” police. Finding well qualified investigators or individuals with a propensity for investigation from outside the ranks of former police officers has been a difficult task for those recruiting staff for the SIU. This appears to be a prevailing problem for jurisdictions banning all former police officers from investigative oversight agencies. Using former police is essentially treated as the lesser of two evils: better to have former officers than serving officers. Maintaining objectivity is much more feasible than in systems using seconded or internal police.

### **Newcomers to the Field: Alberta Serious Incident Response Team (ASIRT) & Saskatchewan Public Complaints Commission (PCC)**

Recently, two additional Canadian provinces have followed in the footsteps of Ontario and implemented their own models of external police oversight: the Alberta Serious Incident Response Team (ASIRT) and Saskatchewan’s Public Complaints Commission (PCC). While these agencies are indeed external to the police agencies being investigated, they do not come as close as Ontario to a genuinely comprehensive approach to civilian investigation of all serious allegations of police wrongdoing.

#### **ASIRT-Alberta**

The Alberta Serious Incident Response Team (ASIRT) was Alberta’s response to the need for an independent oversight body to conduct investigations into serious injury or death arising from police related incidents in that province. ASIRT was an initiative of Alberta’s Solicitor General, becoming operational in 2007.

ASIRT uses a blend of civilians and seconded police officers, including both municipal as well as RCMP police officers who work together on investigations. In Alberta, several municipalities have their own municipal

police agencies, including the two largest cities, Edmonton and Calgary, as well as some smaller cities such as Camrose, Lacombe,<sup>4</sup> Lethbridge, Medicine Hat and Taber have established their own municipal police forces. Rural areas are primarily policed by the RCMP which is contracted to provide provincial policing in the province. It also polices a number of First Nations communities in the province. Additionally, the RCMP is under contract to provide policing in a number of small towns throughout the province. This presents a more complicated picture for police oversight than Ontario where the vast majority of policing is under direct local control. Historically, the use of the RCMP to provide contract policing presented issues regarding accountability of a federal entity to a locally created oversight agency;<sup>5</sup> however, it is readily accepted that ASIRT can investigate alleged wrongdoing involving both municipal police and the RCMP in that province.<sup>6</sup> As of 2011, the Yukon Territory was in the process of contracting with Alberta to use ASIRT to investigate alleged wrongdoing by the RCMP officers working in that jurisdiction.

At present, all but one of the civilian investigators in ASIRT are former police officers (Purvis, 2011). The mandate of the agency is to investigate incidents or complaints involving the serious injury or death of any person and matters of a serious or sensitive nature that may have resulted from the actions of a police officer, in accordance with s. 46.1 of the *Alberta Police Act*. ASIRT is led by a civilian director and consists of a civilian assistant director (currently Roy Fitzpatrick, whose prior service includes work with both the RCMP and the Calgary Police Service), two civilian criminal analysts, four civilian investigators, ten sworn police officers (from the Calgary Police Service, Edmonton Police Service, and the RCMP), and four contract investigators, all of whom report to the Director, currently Clif Purvis, a lawyer and crown prosecutor who was seconded from Alberta Justice to become responsible for the establishment and implementation of ASIRT. As the civilian Director, he is responsible for ensuring what are

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<sup>4</sup> The Lethbridge Police Service is actually a regional police force serving both Lethbridge and the nearby town of Coaldale.

<sup>5</sup> See *AG (Alta.) v. Putnam*, [1981] 2 S.C.R. 267 holding that the province had no jurisdiction over discipline of RCMP officers operating under contract in that province. This prohibition was also held to preclude the province from authorizing an inquiry into alleged wrongdoing by RCMP officers since the Alberta legislation envisioned that such inquiries would inevitably lead to discipline in the event wrongdoing was uncovered.

<sup>6</sup> However, ASIRT does not have the authority over Alberta Sheriffs who are increasingly responsible for Highway Patrol functions throughout the province.

claimed to be independent, objective investigations into s. 46.1 incidents. According to s. 46.2 of the *Police Act*, the Director of ASIRT is defined as a Chief of Police for the purpose of s. 46.1 investigations.

ASIRT does not have the ability to self-initiate investigations. All complaints about police wrongdoing are lodged with the Chief of Police of the officers in question. All of those involving serious injury or death, and those of a “serious or sensitive nature” are forwarded by the Solicitor General. ASIRT does not directly take complaints from the public. The Minister, or his delegate, the Director of Law Enforcement, may call upon ASIRT to carry out the investigation of any of these incidents. After the completion of an ASIRT investigation, the ASIRT director reviews the results of investigations to ensure completeness and fairness. A report may be forwarded to the office of the Crown Prosecutor requesting an opinion on whether charges should be laid. The Director has the authority to decide what charges, if any, will result from the investigation.

Although relatively new, ASIRT has successfully completed numerous investigations, and appears to be heavily burdened with the workload presented to it.<sup>7</sup> ASIRT completed its first investigation in November 2008 and in early 2009, for the first time, laid criminal charges when an RCMP officer was charged with sexual assault.<sup>8</sup> In June of 2009, a Calgary Police Service officer was charged with the cybercrime offence of luring a child following an investigation by ASIRT.<sup>9</sup> After an ASIRT investigation, an Edmonton RCMP officer was charged with numerous counts of assault in an incident involving a family dispute.<sup>10</sup> Following an investigation into an alleged assault by an Edmonton officer, a charge was laid in October of

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<sup>7</sup> See Victoria Handysides “Watching the Watchmen: Investigations into Police Shootings Taxing Staff Resources: ASIRT Chief” Metro Edmonton, May 29, 2009. Available at: [www.metronews.ca/edmonton/local/article/236860--watching-the-watchmen](http://www.metronews.ca/edmonton/local/article/236860--watching-the-watchmen)

<sup>8</sup> “Mountie Arrested and Charged with Sexual Assault After Probe” Metro Edmonton, January 8, 2009. Available at: [www.metronews.ca/edmonton/local/article/163519](http://www.metronews.ca/edmonton/local/article/163519)

<sup>9</sup> “Calgary Police Service Officer Charged with Luring a Child Online” Orleans Star, June 11, 2009. Available at: [www.orleansstar.ca/pages/article.php?noArticle=123091020&CP=1](http://www.orleansstar.ca/pages/article.php?noArticle=123091020&CP=1)

<sup>10</sup> “Alberta RCMP Corporal Charged with Seven Criminal Offences Including Assault” Orleans Star, September 21, 2009. Available at: [www.orleansstar.ca/pages/article.php?noArticle=225386229&CP=1](http://www.orleansstar.ca/pages/article.php?noArticle=225386229&CP=1)

2009.<sup>11</sup> Additionally, charges of assault and obstruction were laid against an RCMP officer working in Lac La Biche for injuries sustained by an individual in police custody.<sup>12</sup> To date, no deaths in police custody or other police-involved deaths have resulted in ASIRT recommending charges be laid, although they have investigated a case in which police shot and killed a suspected car thief who was attempting to evade arrest, and a case in which an individual being brought into custody died after a conducted energy device was deployed on him (ASIRT, 2010).

### **Evaluation of ASIRT**

ASIRT was created as an “integrated unit” to investigate cases of serious injury or death, including other serious or sensitive matters, involving police. While ASIRT is relatively new, having been in existence for only two years, it was successful in 2009 in laying criminal charges against five police officers (ASIRT, 2010).

Since ASIRT has no powers to initiate investigations on its own, it is reliant on the Ministry to provide it with appropriate cases to look into. Cases involving deaths and serious injuries arising in police conduct may be allocated to ASIRT; however, the Ministry retains discretion to withhold these cases from the agency and allow another police force, or even the force in which the incident arose to conduct the investigation. While there may be rare cases in which death or serious injury arise in which it is appropriate for the agency involved in the incident to do the investigation, it would clearly increase public confidence if it was ASIRT itself that was exercising discretion to allow the home force to investigate rather than the Ministry responsible for policing in the province. The 2009 Annual Report reveals the following mix among the 32 files assigned to it in 2009:

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<sup>11</sup> “Former Hero Cop Charged with Assault” Edmonton Sun, October 28, 2009. Available at: [www.edmontonsun.com/news/edmonton/2009/10/28/11557436.html](http://www.edmontonsun.com/news/edmonton/2009/10/28/11557436.html)

<sup>12</sup> “Alberta Mountie Charged with Assault” Calgary Sun, December 22, 2009. Available at: [www.calgarysun.com/news/alberta/2009/12/22/12237346-sun.html](http://www.calgarysun.com/news/alberta/2009/12/22/12237346-sun.html)

Type of Case	Number	Percentage
Sensitive Allegation	12	38%
In-custody Injury	7	22%
Sexual Assault	4	13%
Firearm Death	3	9%
Vehicle Injury	2	6%
Vehicle Death	2	6%
In-custody Death	1	3%
Other	1	3%

Source: ASIRT (2010)

The Alberta *Police Act* does not define the terms “serious injury” or “matters of a serious or sensitive nature”, key triggers for Ministry notification and accordingly key factors in delimiting the cases ASIRT is potentially assigned to investigate. While this appears to constitute a serious oversight, at present those responsible for administering the Act are aided by a protocol issued by the Ministry. This protocol seeks to define these terms as follows:

Serious injury shall include injuries likely to interfere with the health or comfort of the complainant that are more than merely passing or trivial in nature. A serious injury shall initially be presumed when the complainant is either admitted for a stay in hospital or suffers severe trauma to the body (or both) with the injury including, but not limited to:

- A fracture or combination of fracture and severe trauma to a limb, rib or vertebrae or to the skull including the probability of a head injury;
- Burns or abrasions to a major portion of the body;
- Loss of any portion of the body;
- Loss of mobility (paralysis) of any portion of the body;
- Loss of vision or hearing;
- Injury to any internal organ;
- Loss of consciousness brought about by a state of extreme mental distress, prolonged agitation and/or combative behavior which collectively may be classified as symptoms of excited delirium.
- Serious injury shall be presumed in instances where a prolonged delay may be likely before the nature and seriousness of injury can be assessed

Serious injury will be presumed in ALL instances where:

- A sexual assault is alleged;

- A gunshot wound of any degree of severity is sustained by a person as a result of a firearm fired by a police officer (Alberta Solicitor General and Public Security, 2009a).

The protocol goes on to require Ministry notification in all cases where there is doubt as to the applicability of the requirement. The Ministry has also developed guidelines to determine whether an incident is of a “serious or sensitive” nature. It obviously requires the exercise of discretion in determining whether a situation falls into this category. The Ministry protocol provides examples that it claims fit into the category since they may bring the administration of justice, and more particularly the police service in question, into disrepute. The list of examples includes the following allegations:

- A firearm was discharged at a person by a police officer;
- Sexual assault by a police officer;
- Aggravated assault by a police officer;
- Criminal fraudulent activities by a police officer;
- Serious breach of trust by a police officer;
- Potential systemic racism or discrimination; and
- Potential systemic fraud or corruption (Alberta Solicitor General and Public Security, 2009b).

Of course, this is not an exhaustive list, and new situations may well be considered to fall within the ambit of the notification requirement under the “serious or sensitive nature” clause, with the potential for media interest being an obvious factor to be weighed in determining whether Ministry notification is appropriate. The terms “serious injury” and “serious or sensitive” appear to be concepts whose meaning is in a state of flux, gradually evolving over time.

The Alberta *Police Act* is clearly designed to apply to municipal (and regional) police forces, making little reference to the RCMP which does much of Alberta’s policing under contract. No doubt, it is inappropriate on constitutional grounds for Alberta to legislatively intrude into the management of the RCMP; however, since the *Act* clearly intends for ASIRT to investigate both municipal and RCMP officers, the *Act*’s wording is at time tortured in its application to the RCMP. For example, the Ministry reporting provisions (s. 46.1) are made applicable to the pertinent “chief of police,” a term normally associated with municipal police departments. Since the *Act* is also expected to apply to the RCMP, the pertinent protocols (Alberta Solicitor General and Public Security, 2009a and 2009b)

call for the “Commanding Officer” of RCMP detachments to make such reports as well as department chiefs.

While ASIRT incorporates a mix of civilians and seconded municipal and RCMP officers, at present even the civilians are ex-police officers. According to ASIRT’s Director, the most qualified candidates for the civilian investigator positions were ex-officers, and as a result were hired. This makes the ASIRT model a mix of ex-police and seconded police, rather than a mix of those with and without a police background. The use of former and seconded police is problematic. The agency will not have the same credibility with the public that one can expect from a genuine civilian agency in that one still has police investigating police. Investigations may be fair and unbiased, yet the process will always be tainted by the perception that the police are investigating themselves and protecting one another. Allowing the police to take control, particularly when the entire investigative team is comprised of police, creates an appearance of bias. This jeopardizes the independence, integrity, and legitimacy of the process and oversight body. This model runs the risk of ultimately resulting in (ex-) police investigating police with police culture and police values permeating through the organization, hindering its ability to remain objective. While the continuing involvement of retired and seconded police may be problematic, the obvious advantage to the Alberta model over that employed in numerous other provinces is that it is a civilian-led agency. It can also be hoped that, over time, the hiring of civilian investigators without prior police connections occurs. A realigned balance of civilian and police investigators operating under a civilian director may present a viable approach to external investigation.

### **PCC-Saskatchewan**

Saskatchewan’s Public Complaints Commission (PCC) was established in 2005 in an effort to increase public confidence in the accountability of police in that jurisdiction. It provides civilian oversight of the investigation of public complaints against the actions of municipal police in the province. Additionally, the PCC was created to improve the relationship between Saskatchewan’s Aboriginal population and the police. The PCC is part of the Saskatchewan government’s response to both the Stonechild Inquiry and the Commission on First Nations and Métis Peoples and Justice Reform (Government of Saskatchewan, 2006). The PCC became operational in April 2006 and replaced the office of the Saskatchewan Police Complaints Investigator (PCI).

The Saskatchewan PCC is an “independent”, non-police body, consisting of 5 individuals including a chairperson and vice-chairperson. Members of the

board are appointed by the Lieutenant Governor in Council for a three-year term, with the possibility of one renewal. According to 2005 amendments to the legislation, the composition of the board must include the following: one member of the board must be a person of First Nations ancestry, one member must be a person of Métis ancestry, and one member must be a lawyer (Province of Saskatchewan, 2008). This provision ensures the board is representative of Saskatchewan's population and has someone with legal expertise. The PCC investigative staff consists of civilians and retired/former police officers from local police forces, the federal police force, or abroad.

In addition to the five-person Commission, the organization has a Director. The Director at present, John A. Clarke, is responsible for the daily operation of the PCC. The PCC legislation resulted from consultations conducted with the Saskatchewan Association of Chiefs of Police, the Federation of Saskatchewan Indian Nations, the Saskatchewan Federation of Police Officers, local police boards, and the Métis Family and Community Justice Services.

The role of the PCC is to receive, investigate, and review complaints against the police or possible criminal offences committed by person(s) serving with the police. The PCC has direct control over who conducts the investigation into any public police complaint, including all criminal matters. It is also able to complete an investigation into a criminal allegation against a member or chief of police even after that member or chief resigns. The commission has jurisdiction over all municipal police officers in Saskatchewan; however it does not have jurisdiction over RCMP members who make up a very large proportion of the police serving in that province.<sup>13</sup>

When determining how an investigation of a public complaint should be handled, the PCC has the following four options available to them (Saskatchewan *Police Act*, 1990, s. 45(3)): investigation by the PCC itself, using the PCC's investigative staff; allowing the police service whose member is the subject of the complaint to investigate itself; allow the police service whose member is the subject of the complaint to carry out the investigation with the assistance of an outside observer who is appointed by the PCC to monitor the investigation and report back to the PCC; or, to have a separate police service (other than the police service whose member

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<sup>13</sup> Like Alberta, major cities in Saskatchewan such as Regina and Saskatoon have their own municipal police force, while the RCMP provides rural and small town policing under contract.



is the subject of the complaint) conduct the investigation. In cases, where it deemed to be appropriate, complaints can be resolved through mediation or informal resolution. In cases where the PCC does not conduct the investigation itself, the PCC will review the investigation for thoroughness, returning cases for further investigation if required. If the PCC is dissatisfied with the way in which an investigation is being carried out, it may take over the investigation itself or reassign the investigation (s. 45(6)).

The PCC has the authority to generate a public complaint on its own initiative without waiting for an aggrieved party to come forward (s. 38(1)). It has jurisdiction over both minor public complaints and public complaints requiring a criminal investigation of alleged police wrongdoing (s. 45(2)). In cases involving serious injury or death, the police service concerned must request that the Deputy Minister of Justice appoint an investigation observer “from another police service or detachment of the RCMP” to oversee the investigation (*Saskatchewan Police Act, 1990*, s. 91.1(1)). This provision applies to deaths in RCMP custody as well as deaths in municipal police custody. The investigation observer in these cases will monitor the investigation and report back to the Deputy Minister, not the PCC. The term “serious injury” is not defined in the Act.

### **Evaluation of the PCC**

The PCC is an agency that is specifically designed to impartially review, investigate, and in appropriate cases resolve complaints against the police. In addition, it was created in an effort to increase public confidence in the accountability of police in a province where the public had become concerned about the interactions of the police with the Aboriginal population.<sup>14</sup> This commission is quite unique in its orientation and make-up. It consists of five civilians, all of whom were chosen to reflect the general make-up of Saskatchewan’s population. While no member of the panel can be a former, retired or active police officer, members can be reappointed for a second term, and thus the reliance on retaining government favor may lead one to conclude that this agency is not entirely independent from government interference.

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<sup>14</sup> The Stonechild Inquiry was concerned with the practice of police officers taking breach of the peace detainees to the outskirts of town and abandoning them. Neil Stonechild was a young Aboriginal man who died from hypothermia in the outskirts of Saskatoon. Allegations were made that the police abandoned him in that location; however, the inquiry failed to produce conclusive evidence that this occurred (Wright, 2004).

It is worthy to note that the panel or board usually has complete power and discretion when deciding how to proceed with an investigation. However, almost all of the options available to the PCC involve using “active” police to investigate police. In fact, one of the options allows the very police department whose member is the subject of a complaint to investigate. This is the hallmark of non-progressive police oversight models.

In cases where a police department is permitted to conduct an investigation into its own members’ actions that have resulted in death or serious injury, an investigative observer is appointed by the Deputy Minister of Justice. This observer is typically a police officer from another police department. It has never been an investigator from the PCC’s investigative arm that fulfills this role (Clarke, 2010). It is unfortunate that the legislative scheme does not mandate civilian involvement in the conduct of these investigations. In at least one police-involved shooting, the observer was a representative from the Federation of Saskatchewan Indian Nations’ (FSIN) Special Investigations Unit (SIU) (Clarke, 2010).<sup>15</sup> Involving a representative of the Aboriginal organization to observe the conduct of a serious investigation incident involving an Aboriginal victim is an obvious good start; however, it is difficult to rationalize the failure to involve non-police PCC investigators in the conduct of all serious investigations.

All of the investigators working for the PCC appear to be former police officers. Indeed, in their job postings seeking to fill the position of PCC investigators, they specifically recruited individuals with extensive police experience in either a municipal agency or the RCMP. Ostensibly, this was done to secure the best “subject matter experts”; however, it does little to allay concerns among the public that the police (or ex-police) are still in charge of investigating the police.

The PCC model’s main strength comes from its panel which consists of non-police officers, representing an impartial, neutral, and legitimate oversight body that is representative of the diverse Saskatchewan community. However, the PCC has very limited options available to it in handling investigations. If investigations are not handled by the PCC’s staff, the remaining three options involve the police continuing to investigate the

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<sup>15</sup> The Federation of Saskatchewan Indian Nations represents 74 first nations in that province. In 2000, it established a Special Investigations Unit with two private investigators who looked into complaints about Aboriginal treatment in the justice system. The unit continues to play an active role in assisting Aboriginal victims who wish to initiate a complaint against a police agency through the Police Complaint Commission or another appropriate venue. It also monitors the ongoing status of complaints.

police. Although having the PCC oversee the results of investigations committed by the police gives a small sense of oversight, allowing police to investigate police without the control resting in the hands of civilians is not an ideal approach.

It is troubling that the available options prevailing four years after the creation of the new regime in Saskatchewan still involves the police being called upon to investigate the police, particularly in the most serious cases, with little to no civilian involvement in the conduct of death and serious injury investigations. The lack of civilian investigation as an option is a major flaw in the current PCC model.

To its credit, the PCC is unique among police oversight agencies in that it has a role to play in handling public complaints, criminal allegations, and even internal investigations in some cases. Many other oversight agencies handle only the most serious cases, leaving minor wrongdoing and internal affairs matters solely to the police agencies involved.

### **Manitoba-Independent Investigation Unit (IIU)**

In the winter of 2005 in East St. Paul, Manitoba, an off-duty police officer from Winnipeg who had been drinking collided with a car killing its occupant. The investigation that followed was soundly criticised as unprofessional, and in some aspects, based on bad faith (Salhany, 2008). The incident gave rise to the Taman Inquiry, conducted by Justice Roger Salhany (2008). The Commission found the police officer involved in the incident was given different treatment by the police investigators than a non-police officer would be likely to receive in the same circumstances. As a consequence of the botched investigation, no alcohol-related charges were brought against the officer and his subsequent conviction for dangerous driving causing death resulted in a community disposition, perceived by many as an overly lenient disposition. A key recommendation arising from the Inquiry report was a call for Manitoba to create an independent unit to investigate any alleged criminal activity committed by police officers (Salhany, 2008, p. 139).

In the Spring of 2009, the government of Manitoba announced its decision to create an Independent Investigation Unit (IIU) to investigate deaths in custody and cases resulting in serious injury involving police. Manitoba is one of the latest Canadian provinces to commit to making such a move. Under the new *Police Services Act*,<sup>16</sup> the IIU will be responsible for investigating the following incidents: death or serious injury that may have resulted from the actions of a police officer, contraventions of prescribed provisions in the *Police Services Act*

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<sup>16</sup> The Police Services Act, S.M. 2009, c. 32.

*Regulations* that include certain offences under the *Criminal Code* and other enactments,<sup>17</sup> and any other cases involving allegations of illegality against police where there is a public interest in an independent investigation.<sup>18</sup>

In the new legislation, the protocol for handling less serious criminal allegations requires police services to immediately inform the IIU of a complaint. Following this, the IIU may monitor investigations conducted by professional standards units that are internal to police services. Additionally, the IIU has the power to take over any investigation. Police services are required to report the results of investigations to the Director of the IIU, and police professional standards units must do any follow-up investigations directed by the IIU (Government of Manitoba, n.d.). All non-criminal complaints are dealt with by police services or the Law Enforcement Review Agency (LERA), an independent agency responsible for investigating complaints regarding minor wrongdoing by municipal police officers in the province. Complaints pertaining to police policy are the responsibility of the local police boards and chiefs of police.

Manitoba's new IIU was developed to address serious harm and deaths arising from the conduct of police officers. It was established under the new *Police Services Act* with the mandate to investigate on-duty and off-duty incidents involving police. It is under the direction of an experienced civilian Director who is independent of all police services. The IIU; it is mandatory for fatal force and serious injury cases; it has the power to take over other investigations involving less serious allegations of criminal conduct by police; it is composed largely of experienced, current investigators who are selected, supervised by, and report to the civilian director; investigators selected for the unit would have to meet investigate and ethical standards established by the new police act and steps would be taken to ensure their skills are maintained at a high level; it is supported by civilian monitors and independent legal counsel during and after investigations; and accountable through regular reporting to the public (Consultation Paper: IIU).

The Independent Investigation Unit (IIU) will be led by a civilian director who is independent of all police services. The duties and powers of the director are set out under the new police act. The director of the IIU reports to Manitoba Justice and operates independent of all police services. The IIU will be staffed with "highly skilled investigators from police services in Manitoba and assigned to the unit". The director may also employ the use of civilian

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<sup>17</sup> Ibid. s. 65.

<sup>18</sup> Ibid. s. 75.

investigators “who meet the standards under the act”. (At the moment, the Independent Investigation Unit (IIU) is in the process of hiring its staff). The IIU will operate from its own independent office in Winnipeg. The new model also includes the use of civilian monitors to observe investigations of police officers. Based on the nature of a complaint or incident, the director of the IIU must contact the Manitoba Police Commission to assign a civilian monitor to a case.

### **Evaluation of the IIU**

The government of Manitoba announced its decision to amend the *Provincial Police Act* in 2009. One of the major elements of the new Act was the inclusion of an independent unit to investigate cases resulting in death or serious injury to a member of the public after being in contact with police. While this new model includes some important provisions not currently used in other jurisdictions, it disappointingly mimics the shortcomings displayed by some of the models already identified.

There are numerous positive aspects to the new IIU model. First, the IIU’s mandate includes not only the ability to investigate on-duty police officers, but *off-duty* police officers as well. Indeed, this is a necessary provision that all police oversight models operating in all jurisdictions should adopt in their mandates. There have been too many cases where a police officer in question was “off-duty” thereby negating the application of external investigation mechanisms.<sup>19</sup> In fact, some recent high profile cases resulted in death or serious injury to a member of the public.<sup>20</sup> Even though a police officer is “off-duty”, it is still expected that their conduct will comply with the standards expected of a police officer sworn to uphold the law.

It is notable that the IIU model proposes the use of independent prosecutors. Their role is to determine whether charges should be laid, and where the evidence warrants, prosecute the case. Under their new scheme, independent prosecutors would be brought in from another province. The idea of going

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<sup>19</sup> For a discussion of the application of oversight to off-duty conduct in Canada, see: Paul Ceysens “Off-Duty Police Conduct: A Discussion Paper (June 2000). Available at: [www.llbc.leg.bc.ca/public/pubdocs/bcdocs/341409/ceysens.pdf](http://www.llbc.leg.bc.ca/public/pubdocs/bcdocs/341409/ceysens.pdf)

<sup>20</sup> For example, in 2009 a newspaper delivery man was assaulted by several off-duty police officers in Vancouver ([www.cbc.ca/canada/british-columbia/story/2009/07/17/bc-west-vancouver-newspaper-deliveryman-hotel-beating.html](http://www.cbc.ca/canada/british-columbia/story/2009/07/17/bc-west-vancouver-newspaper-deliveryman-hotel-beating.html)), and Benjamin Monty Robinson, one of the RCMP officers involved in the Dziekanski taser-death incident was involved in an off duty drinking and driving incident that resulted in the death of a motorcyclist ([www.cbc.ca/canada/british-columbia/story/2009/03/04/bc-monty-robinson-rcmp-impaired-driving.html](http://www.cbc.ca/canada/british-columbia/story/2009/03/04/bc-monty-robinson-rcmp-impaired-driving.html)).

outside the provincial attorney general ministry's own Crown prosecutors is a good idea. Local Crown prosecutors typically develop close relationships with police during their day-to-day work. Any possible bias is minimized by circumventing their involvement in the decision to prosecute police. The use of private local counsel is the obvious alternative. However, police may be concerned with the possibility that local defence counsel will hold animosity towards the police and accordingly be biased against them. The Manitoba legislation appears to be unique in mandating the use of independent counsel from outside the province. While this avoids the likelihood of bias either for or against local police, it seems odd that legal counsel, being regulated by the provincial law society, would be brought in from another jurisdiction.

While the IIU has followed in the footsteps of other models by using a civilian Director, it has also made the same mistakes as several other models in allowing IIU investigators to be serving or ex-police officers. A point of major concern with this model is that it allows for the use of police from the force that is under investigation. The use of "civilian investigators" is envisioned under the Act, but only those individuals "who meet the standards under the Act" will be considered for employment in that role. ASIRT's model is based on a similar provision in the Alberta legislation, but the civilian investigators are entirely comprised of retired and other ex-police officers. It is hard to imagine that the IIU will be any different in this regard. The IIU may also employ the use of civilian monitors to "observe" investigations of police officers. However, despite how many "civilian monitors" are used, if the investigations themselves are still being done by police, the quality of the investigation is open to question by the public, with a strong perception of bias that cannot be ignored. In any given case, the conclusion must be supported by the evidence provided by investigators. Manitoba's new IIU model seems to be yet another example of a faulty system of police oversight that still results in police investigating police in the majority of cases.

Perhaps the biggest concern with the Manitoba developments has been the length of time they have taken to come to fruition. As of May, 2011, Manitoba had still not created its new unit. This fact was lamented in the wake of an RCMP-involved shooting in Gods Lake, Manitoba in March of 2011 (Marshall, 2011). That incident was investigated by the Saskatoon Police Service since the new unit was still not up and running.

### **British Columbia**

British Columbia has witnessed a number of high-profile cases involving allegations of serious police wrongdoing. However, it has been slow to react to the legislative developments arising elsewhere in Canada. In 1994, Justice Oppal, then sitting on the B.C. Court of Appeal, conducted a sweeping review

of policing in the province (Oppal, 1994). Included in his final report were recommendations for the reform of the police complaints and investigation process. One of his recommendations called for the creation of a civilian police complaints commission that should have the authority to supervise police investigations of complaints (which occurred in 1998) and call them to account for their investigations (which did not occur), and a power to actually conduct investigations in appropriate cases (which also did not occur). The current powers of the Police Complaint Commissioner in B.C. are generally restricted to receiving complaints, providing informal mediation, and ordering a public inquiry in appropriate cases.<sup>21</sup> In recent years, the Office of the Police Complaint Commissioner has also taken on the task of overseeing internal police investigations through the review of reports submitted by the professional standards investigators of the police agency conducting an investigation.

In 2007, the B.C. government again heard from an Inquiry that recommended changes to the process for investigating allegations of wrongdoing by the police. In his *Review of the Police Complaint Process in B.C.*, former B.C. Supreme Court Justice Josiah Wood called for enhanced civilian oversight of police investigations of police wrongdoing (Wood, 2007). However, while Mr. Wood refrained from recommending genuine independent investigation, he cautioned that a future review should be conducted to determine whether police controlled investigations with civilian oversight was achieving its objectives. The implication was clear, if civilian oversight proved to be inadequate, then an independent investigative force would be the only viable alternative.

In 2007, former B.C. Supreme Court Justice William Davies began an Inquiry into the death of Frank Paul, a man who had been in the custody of the Vancouver police immediately prior to his death in 1998. In his interim report, Mr. Davies soundly criticised the notion that a police department should be allowed to conduct the investigation of a death connected with that very same department, as was the case in this incident (Davies, 2009). He recommended that police-involved deaths be investigated by a genuine independent civilian agency. His final report was submitted to the B.C. government in May of 2011, but has not yet been released to the public.

In recent years, particularly following the criticism that attached to the Frank Paul investigation, high profile cases of alleged serious police wrongdoing in B.C. were referred to an outside police agency for investigation. However, this often occurred in tandem with internal investigations. In all cases, the initial

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<sup>21</sup> *Police Act*, RSBC, c. 367, s. 50.

portion of the investigation including securing evidence and taking initial witness statements was always conducted by officers belonging to the same police agency as the officer who was alleged to have committed the wrongful acts. Following the flurry of reports calling for change in B.C., the provincial government finally responded with a legislative amendment to the police complaint provisions of the B.C. *Police Act* in 2009. In 2010, the amendments to the *Police Act* were brought into force, instituting a new procedure for dealing with alleged serious police wrongdoing. The new scheme formally authorized the external investigation by a different police agency of serious police wrongdoing.<sup>22</sup> However, this response represented a minimal change in that it did nothing more than reflect the existing practice of using neighbouring police departments to conduct investigations, a practice that was being followed as a matter of course in serious wrongdoing cases over the past several years.

That new scheme for investigating serious police wrongdoing in B.C. did not envision the development of an external civilian agency, or even an external police-staffed agency with a civilian head. Instead, it used police from other police agencies in the province to carry out the investigation of allegations of serious wrongdoing.<sup>23</sup> This process was only to be used for cases resulting in death while in police custody or care, cases in which serious harm had been suffered, and in cases of reportable injuries. Reportable injuries were defined in s. 76 of the *Act* as including those resulting from the use of a firearm, those requiring hospitalization and those prescribed by regulation. In addition to these scenarios, an external investigation could be ordered by the police complaint commissioner where that official found it to be “necessary in the public interest” to do so.<sup>24</sup> Similarly, if a police chief who found an external investigation of an officer’s conduct to be in the public interest, the chief could so order such an investigation, provided the Police Complaint Commissioner approved of this measure.<sup>25</sup> The Police Complaint Commissioner could also

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<sup>22</sup> Police (Misconduct, Complaints, Investigations, Discipline and Proceedings) Amendment Act, 2009. Bill 7, 2009. In force, March 31, 2010. This Bill added a new Part 11 to the Act.

<sup>23</sup> Police Act, s. 89(2). The police complaint commissioner must order the investigation be carried out by an external police force or a special provincial constable appointed for that purpose (there are no special constables appointed for this purpose).

<sup>24</sup> Ibid. s. 92(1).

<sup>25</sup> Ibid. s. 92(2).



order the investigation of a municipal police officer's conduct, even where no formal complaint had been filed.<sup>26</sup>

If a police officer from another police agency was appointed to investigate an allegation of police wrongdoing, the investigating officer was to have no connection with the case, and had to be of a rank equivalent to or above the officer being investigated.<sup>27</sup> The Police Complaint Commissioner was entitled to "observe" any investigation ordered under Part 11 of the *Police Act*.<sup>28</sup> Monitoring of ongoing investigations was authorized through s. 97 of the Act which allowed the Police Complaint Commissioner to require the investigating officer to keep the commissioner or his observer informed of the progress being made in the investigation, including providing copies of records where required.<sup>29</sup> The Complaint Commissioner could also provide advice to investigators and direct that further investigative steps be taken,<sup>30</sup> provided the commissioner had consulted with the investigating officer and the chief to whom the officer was responsible.<sup>31</sup> Investigators were granted various powers to aid them in their investigation,<sup>32</sup> and a duty was imposed on officers being investigated to cooperate, answer questions, and provide a written statement pertaining to the incident being investigated if requested to do so,<sup>33</sup> and all persons had to refrain from hindering investigations.<sup>34</sup>

The reforms of 2010 were not viewed as adequate by many critics. Considering British Columbia was one of the last provinces to amend its

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<sup>26</sup> Ibid. s. 93(1).

<sup>27</sup> Ibid. s. 89 (4)(a).

<sup>28</sup> Ibid. s. 96. For this purpose, the Police Complaint Commissioner may designate an employee to conduct the observation and report to the police complaint commissioner.

<sup>29</sup> Ibid. s. 97(1)(a) and (b).

<sup>30</sup> Ibid. s. 97(1)(c) and (d).

<sup>31</sup> Ibid. s. 97(3). The chief is responsible for ensuring such directions are fulfilled: s. 97(4).

<sup>32</sup> Ibid. ss. 100 - 103.

<sup>33</sup> Ibid. s. 101. Other officers are also under a duty to cooperate with the complaint commissioner when exercising powers and duties under the *Police Act*: s. 178.

<sup>34</sup> s Ibid.. 106.

process for investigating allegations of serious police wrongdoing, it was expected that it would have one of the most progressive and fully developed systems. This could not have been farther from reality. While civilian investigation and civilian-led investigation had become the norm in other jurisdictions that turned their attention to these matters in recent years, B.C. maintained a process that involved the investigation of police officers by other police officers. These investigators were not accountable to a civilian head in any meaningful way. The investigations were conducted by nearby police agencies, ones with which many police officers no doubt had longstanding connections.<sup>35</sup> Investigation of the police by another police agency does little to instil public confidence in the impartiality and thoroughness of an investigation. While the Police Complaint Commissioner was entitled to observe these investigations, and even to provide advice and direction for further investigation, this did little to assuage concerns that the process remained under the control and direction of the police.

The lack of a precise definition of “serious harm” presented problems for delineating the cases that were to be sent for external investigation.<sup>36</sup> To its credit, the *Act* allowed for an external investigation where the “public interest” mandated this response. Granting the power to police chiefs to order an external investigation where the public interest is best served by doing so was also a positive feature of the *Act*. However, it was odd that police chiefs were granted the authority to select the external agency that would conduct the investigation.<sup>37</sup> Placing this decision in the hands of the police complaints

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<sup>35</sup> Municipal police in BC currently train together in mixed classes at the Justice Institute of British Columbia. Additionally, there are numerous joint task forces which promote considerable cross-jurisdictional contact among BC police officers, particularly in the Lower Mainland and Greater Victoria regions. It is also noteworthy that the chiefs of police in Vancouver and Abbotsford, and the Public Safety Minister/Solicitor General for the province, are all former subordinates of the Victoria Police Department’s chief, having worked together in Vancouver.

<sup>36</sup> The *Act* defines serious harm as injury that:

- (a) may result in death,
- (b) may cause serious disfigurement, or
- (c) may cause substantial loss or impairment of mobility of the body as a whole or of the function of any limb or organ (s. 76).

<sup>37</sup> In late March, 2010, the Chief of Victoria’s Police Department requested Vancouver police conduct an investigation into allegations of abuse by a Victoria police officer. The Chief selected Vancouver to conduct the investigation, a department headed by the Victoria Chief’s former subordinate when he worked in Vancouver as its Chief.

commissioner seemed like an obvious step that would help to minimize the perception of bias.

The 2010 B.C. model was fundamentally flawed in its failure to employ an independent civilian run organization staffed by non-police officers. Many jurisdictions in the Commonwealth that have attempted to reform their process for investigating allegations of serious police wrongdoing have moved to models of that nature.<sup>38</sup> B.C. quickly realized that its quick-fix would not satisfy the calls for genuine reform.

In June of 2010, former B.C. Supreme Court Justice Thomas Braidwood released his final report on the death of Robert Dziekanski, who died after being tasered by RCMP officers at the Vancouver International Airport (Braidwood, 2010). Commissioner Braidwood called for far-reaching reforms to the way police wrongdoing was investigated in the province. He recommended the development of a civilian-led Independent Investigation Office (IIO) to probe all cases of death or serious harm arising from police-related incidents. He also recommended that the new agency be responsible for investigating any allegation of a *Criminal Code* violation. He noted the need to clearly define the scope of the concept of “serious harm” to make plain the extent of the new agency’s jurisdiction. Mr. Justice Braidwood called for a civilian leader for the agency who had no prior career as a police officer. The majority of the investigators in the new agency were to be civilians with no prior employment as police officers. Those who had a prior police background could not have worked for a policing agency within the province during the past five years and could not investigate an agency with which they had prior employment experience. After a five year transition period, Mr. Justice Braidwood envisioned the elimination of former police officers in the new organization.

The same day that Mr. Justice Braidwood’s final report was released, the B.C. government announced it would implement the recommendations within a year. In May of 2011, B.C.’s Minister of Public Safety and Solicitor General, Shirley Bond, introduced a Bill into the legislative assembly amending the *Police Act* in order to create an Independent Investigation Office.<sup>39</sup> Bond asserted

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<sup>38</sup> The Police Ombudsman for Northern Ireland uses a civilian led organization composed of non-police officers to carry out such investigations. Similarly, the Office of the Police Complaints Commission in England adopts such an approach. Australian states have likewise moved to civilian-led organizations.

<sup>39</sup> Bill 12 – 2011 *Police (Independent Investigations Office) Amendment Act, 2011*. As of May 27, 2011, that Bill has been approved through second reading and is headed for committee.

that the organization would be built on the Ontario SIU model, and should be active by the end of 2011. While the identity of the Director of the new agency has just been announced, much has been known about the structure of the new organization for months.

The new organization will be led by a civilian Director who “is not a current or former member of a police force or the Royal Canadian Mounted Police.”<sup>40</sup> The Director will be appointed for an initial five-year term and heads an Independent Investigations Office (IIO) that is established within the Ministry of the Attorney General.<sup>41</sup> This new agency will have jurisdiction over both municipal police and the RCMP operating in the province.<sup>42</sup> The investigators in the new office will be responsible for investigating all incidents resulting in death or serious harm<sup>43</sup> as a result of the actions of a police officer, whether or not they were on duty at the time.<sup>44</sup> Additionally, the IIO is empowered to investigate contraventions of a “prescribed provision” in federal or provincial legislation, presumably to be set by regulation in the future. If the IIO investigation reveals that an officer may have committed an offence, the director of the IIO must file a report with Crown Counsel.

The IIO investigators themselves are appointed by the civilian Director. The investigators may be civilians with investigative experience, former police officers from outside the province, or former RCMP officers, provided they have not been a police officer within the province during the five years preceding their appointment.<sup>45</sup> While the legislation allows the hiring of former police officers into the ranks of the IIO, the Premier’s announcement on the tabling of the legislation indicated the goal is that within five years none of the investigators working in the unit will have a prior background in

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<sup>40</sup> Ibid. s. 38.03.

<sup>41</sup> Ibid. s. 38.02.

<sup>42</sup> Ibid. s. 38.01 defines “officer” and “police service” as including the RCMP.

<sup>43</sup> The legislation retains the definition of serious harm enacted in the previous year (defined in Part 11 of the *Act*).

<sup>44</sup> Ibid. ss. 38.09 and 38.10 require IIO investigators to take over such investigations upon arriving at the scene and require police services investigating their own officers’ conduct to call in the IIO where it becomes apparent the IIO has jurisdiction.

<sup>45</sup> Ibid. s. 38.06(2).

policing. The IIO investigators are to be granted peace officer status under the new Bill.<sup>46</sup>

The legislative scheme has one interesting aspect that appears to be unique to B.C. The Bill allows the director of the IIO to appoint a person who is not a current or former police officer to act as a civilian monitor to review and assess the integrity of an investigation being carried out by the IIO.<sup>47</sup> The legislation appears to contemplate this only being done on an *ad hoc* basis. The civilian monitor may compel IIO staff to provide an interview or a statement. The civilian monitor provides the Director with a written report assessing the integrity of the investigation after its completion.

### **Evaluation of the B.C. Model**

The proposed IIO scheme represents a significant step forward in some regards, but still falls short in others. B.C. is, in many ways, at the forefront of the civilian investigative approach to police accountability for serious police wrongdoing. A civilian investigator which ultimately should have a staff of civilian investigators is the most independent and transparent approach.

The definition of “serious harm” is a trigger to IIO involvement. The definition of “serious harm” in Bill 12 is very similar to that proposed by Commissioner Braidwood in his report. However, the definition is quite restrictive.<sup>48</sup> If the experience in Ontario regarding the interpretation of their triggering level of harm, “serious injury”, is any gauge, B.C. can expect to have problems with the way in which the police interpret the phrase. In Ontario, at least one police-involved shooting was not reported to the SIU since it resulted in a gunshot through the shoulder that only produced “tissue damage”, interpreted by the police to be a mere “flesh wound” (Marin, 2008, p. 20). It is unclear whether such an incident would be subject to mandatory IIO involvement in B.C. under its new legislation. Similarly, in Ontario, sometimes the SIU is called in to investigate “fractured rib” cases, at other times it is not, “broken nose” cases no longer attract SIU investigation, and being “beaten black and blue” does not necessarily activate the SIU’s jurisdiction (Marin, 2008, p. 20). The vagueness of the “serious harm” definition leaves some question as to whether the IIO will be mobilized in all cases where the public might deem it appropriate. The legislation should include mandatory investigation of all cases involving police shootings, and

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<sup>46</sup> s. 38.07(1)(a)

<sup>47</sup> s. 38.08.

<sup>48</sup> See the definition *supra*, note 34.

any “reportable injury” as defined in s. 76 of the *Police Act*. There appears to be no rationale for allotting these investigations to outside police forces in the 2010 amendments, but not assigning them to the IIO through the 2011 amendments. They pertain to cases in which the public is bound to demand unbiased external investigation. It may also be advisable to expand the definition of “serious harm” to include severe psychological harm and serious soft tissue injury.<sup>49</sup>

The Braidwood Commission Report (2010) called for a slightly stronger version of a civilian investigation agency than appears in the government’s announced reform package. In particular, Mr. Braidwood called for mechanisms to ensure witness officers (those police officers with knowledge of the incident, but not the subject of the investigation itself) make themselves promptly available for a interview by the IIO, and provide all notes, reports and other pertinent documentation. Additionally, he called for respondent officers (those directly implicated in the alleged wrongdoing) to provide pertinent materials to IIO investigators. He also called for entrenched rules segregating involved officers, and prohibitions regarding communication amongst involved officers prior to IIO involvement. Neither of these recommendations are available to IIO investigators through Bill 12. Provisions dealing with these matters, found in Part 11 of the *Act* dealing with investigations of police wrongdoing by other police agencies, should be made applicable to investigations by the IIO under Part 7.1 of the proposed amended *Act*. Mr. Braidwood also called for the use of special prosecutors to deal with all police-related incidents dealt with by the IIO; another recommendation not addressed in the reform bill. Finally, Mr. Braidwood called for the provincial Ombudsman to have jurisdiction over the IIO. The new Bill does not seek to extend the Ombudsman’s jurisdiction to the new agency.

The Braidwood recommendations that did not make their way into Bill 12 are important matters. They are issues that have been a cause of concern in Ontario where investigations by the SIU have been subjected to criticism. As noted previously, the Ontario Ombudsman, André Marin, conducted an extensive review of the SIU (Marin, 2008). In his report, Marin notes that Ontario enacted regulations governing the conduct and duties of police officers during SIU investigations.<sup>50</sup> That regulation was found to be necessary

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<sup>49</sup> These recommendations were also advanced by Marin (2008) as appropriate in the Ontario context.

<sup>50</sup> Conduct and Duties of Police Officers Respecting Investigations by Special Investigations Unit, O. Reg. 673/98.

to compel timely notification of incidents by the police, control of incident scenes pending SIU arrival and cooperation with SIU in their investigations. These were areas that presented major problems arising from police obstructing efforts by SIU to fulfil its mandate in the early years of that unit's operation. To avoid such problems in B.C., similar regulations should be adopted from the outset or included in the legislation itself. The provisions brought into the *Act* in 2010 mandating cooperation with investigations into wrongdoing by neighbouring police agencies do not appear to have been made applicable to IIO investigations, despite the IIO replacing those investigative practices for many serious incidents. Despite the presence of these regulations in Ontario, the matters covered by them continued to present difficulties for SIU investigators, and were the subject of considerable concern to Marin. Failure to address such issues in B.C. will likely have similar consequences.

The failure to provide for the use of special prosecutors under Bill 12 is a cause for some concern. In Ontario, the matter is not as contentious, since that jurisdiction uses a process of post-charge screening by Crown Counsel. That is, the Director actually lays the charge, and it is only after a charge is laid that prosecutorial staff get involved in carrying the prosecution forward. In B.C., a pre-charge screening process is used. In that system, only a recommendation is provided to Crown Counsel, who ultimately makes the decision whether or not to have the subject charged. Taking the charge decision out of the hands of the Director is problematic in that the decision is left in the hands of a branch of government rather than the independent investigative office. Crown counsel have historically had close connections to the police. Expecting the Crown to impartially weigh the decision to initiate a prosecution is unreasonable. It was B.C.'s Crown counsel that initially decided not to go forward with charges against any of the officers involved in the death of Robert Dziekanski, Frank Paul, Ian Bush, and the numerous other individuals who have died at the hands of the police in this province. According to Vancouver lawyer, Cameron Ward, he has been unable to find any evidence that a police officer has ever been charged for a homicide-related offence arising out of any police-involved death in the province's history (Ward & Chantler, 2010). In a pre-charge jurisdiction, such as B.C., only a special prosecutor should be considered capable of providing an independent charge assessment in cases addressed by the IIO.

### **Maritime Provinces**

In late 2009, Nova Scotia announced it was going to create an independent agency to investigate allegations of serious police wrongdoing.<sup>51</sup> By late 2010,

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<sup>51</sup> CBC News Online. (November 24, 2009). Independent Unit to Probe Police Misconduct Complaints. Available online at: [www.cbc.ca/canada/nova-scotia/story/2009/11/24/ns-police-independent-unit.html](http://www.cbc.ca/canada/nova-scotia/story/2009/11/24/ns-police-independent-unit.html)

Nova Scotia had released details of its new Serious Incident Response Team,<sup>52</sup> asserting it would be operational by late 2011 (CBC News, 2010). Nova Scotia's Justice Minister, Ross Landry, noted that the new team will be composed of a civilian director, two civilian investigators, and a number of seconded police investigators. The team will be mandated to investigate "serious matters such as death, serious injury, sexual assaults or public interest concerns..." (CBC News, 2010). The Nova Scotia investigative unit will have jurisdiction over both municipal police and the RCMP operating within the province. The civilian Director may not have previously served as a police officer. The Director will be responsible for laying charges following the completion of investigations. Many of the investigators will be seconded from police agencies within the province, but come under the command and control of the civilian Director.

According to David Burchill of the Nova Scotia Department of Justice (2010), Nova Scotia officials have been in consultation with their counterparts in neighbouring Maritime provinces, exploring the possibility of a regional unit, or a unit with regional representation, permitting the use of the new agency to investigate allegations of police wrongdoing in those provinces. To date, neither New Brunswick nor Prince Edward Island appear to be interested in establishing their own independent investigative unit, nor do they appear to have become involved in the developments of the Nova Scotia unit.

### **Evaluation of the Nova Scotia Model**

The Nova Scotia model suffers from the same weakness as other models using seconded police officers. Indeed, the Nova Scotia model permits the seconded officers to investigate their own home department, so long as they are not the lead investigator.<sup>53</sup> The creation of the new agency with a civilian Director and some civilian investigators is to be commended. However, the legislation falls short as a transparent and genuinely independent entity in comparison to the model in place in Ontario.

### **Quebec**

In Quebec, the Public Safety Minister has established policy to govern the investigation of deaths and serious injury cases arising from police involvement. That policy requires police from a force other than the one directly involved in the incident to conduct an investigation and make a report to the prosecutorial authorities who decide whether charges are to be laid. In

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<sup>52</sup> Bill No. 72, 2010, An Act to amend chapter 31 of the Acts of 2004, the Police Act.

<sup>53</sup> *Ibid.* s. 26F(4).



February of 2010, the Quebec Ombudsman released a report that looked into this policy governing the investigation of police-involved deaths and serious injuries, producing criticism of the process and provided recommendations for change (Quebec Ombudsman, 2010). However, there appears to have been no movement on this front.

## **Conclusion**

The reform of the process through which police-involved deaths and other serious injuries are investigated and prosecuted in Canada has moved through a haphazard process of change over the last three decades. No doubt, the split jurisdiction over policing in Canada between federal, provincial and municipal governments has contributed to the slow pace and uneven nature of change in this area. The fact that many provincial and municipal police across the country are officers working for the national police force under contract to local authorities has undoubtedly contributed to the situation. Historically, the RCMP have been immune from local efforts to exert control and discipline over members of that police force. The advent of increased willingness by the RCMP to subject itself to investigation by provincially based investigative agencies in the wake of the Robert Dziekanski tragedy has undoubtedly contributed to significant reforms in recent years. Public dissatisfaction with police investigating police has spurred change across the country.

The new models for investigating allegations of serious police wrongdoing have charted a new course in recent years, overcoming major barriers to change (B.C. Civil Liberties Association, 2010). The model of civilian control of such investigations through an independent investigative agency led by a civilian Director and staffed by civilian investigators has been identified by many critics as the cornerstone of progress in the area of investigating allegations of serious police wrongdoing. Ontario led the way in this regard with its adoption of the SIU in 1990. In more recent years, several jurisdictions have gradually come to employ civilian investigative agencies that are clearly more open and transparent than the process of self-investigation. These agencies have varying degrees of independence, and differing budgets, but each seeks in its own way to provide investigative excellence. While questions remain regarding the appropriate scope of the jurisdiction and powers of the various agencies, each has helped to cut through the blue wall that has long protected police officers from outside review. In the years ahead, it can be hoped that all jurisdictions will remain vigilant to the prospect of improving their mechanism for investigating allegations of serious police malfeasance.

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# Tort Law as a Means of Ensuring Police Accountability

Robert Holmes

## Introduction

Accountability by the law enforcement community is a concept on which, as a general matter at least, there appears to be broad agreement. Political leaders apparently understand that, as witnessed by concerns they express over incidents of clear misconduct by the police that capture the public's attention. The example set by the B.C. government establishing commissions of inquiry in relation to the death of Frank Paul and the death of Robert Djiekanski confirm that.

To their credit, law enforcement agencies profess acceptance of the principle of accountability as well. For example, the RCMP and other police forces expressly setting out "accountability" as part of their core values and commitment to the public.<sup>1</sup> That express public commitment by law enforcement agencies goes hand in hand with the reasonable expectation by the public that law enforcement officers will employ the highest levels of professionalism and skill in their work. To ensure and confirm that, it is only right that the police are amenable to public scrutiny.

The media show their understanding of the accountability principle by the prominence and attention that instances of police misconduct are given.

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<sup>1</sup> Royal Canadian Mounted Police, Mission, vision and values, <http://www.rcmp-grc.gc.ca/about-ausujet/mission-eng.htm>. The Vancouver Police Department has its own Professional Standards Section which reviews matters of internal discipline and reports to the Chief Constable. Its mission statement speaks of accountability in a manner similar to that of the RCMP, saying that their role "is to preserve the integrity of the Vancouver Police Department and the Chief Constable's Office by ensuring that the conduct of VPD members is beyond reproach. The Vancouver Police Department is accountable for the acts or omissions of all of its employees." (<http://vancouver.ca/police/ProfessionalStandards/index.htm>).

The public shows its acceptance of the accountability principle by the interest that they show in such incidents as well. The fact of public attention and debate concerning such matters is a vivid testament to the fact and importance of democratic participation and control over law enforcement agencies. If the public did not have high expectations of law enforcement officers, it would not be likely to react as strongly when examples of misconduct appear.

Finally, those who are directly affected by police misconduct must be taken to agree with the necessity of accountability, as evidenced by the incidence of complaints, civil action and other steps to gain recognition for having had their rights and interests violated.

### **Purposes of Accountability and Mechanisms to Achieve It**

Accountability has several purposes. It can involve obliging government to pay compensation where their corporate acts or omissions or those of individual police officers are wrongful in the eyes of the law and have occasioned injury to others. It can involve setting standards for where the line between acceptable and unacceptable conduct should be drawn. It can involve using a superior authority to make findings and pronounce orders that deter wrongful conduct. It can involve establishing a forum where affected individuals and officials can air their differences and be educated as to what lawful conduct includes. It can involve providing the victims of official misconduct with the procedural means to have their complaints adjudicated in a process that has, at the end at least, an independent and impartial adjudicator. It can involve providing for a means of establishing the truth about what happened and affording victims of official misconduct the opportunity to be recognized as human beings entitled to respect and dignity.

Accountability of the police when questions arise as to their conduct, particularly in relation to persons within their custody or with whom they come in contact, is obviously a key concern for civil society. Without some means of vetting whether police conduct measures up to that which, as citizens in a democratic society, we have authorized the police to do, our confidence in law enforcement would be based upon trust alone. Given that we know that there is a level of error and faulty behavior, it is important that we put in place mechanisms for ensuring both that such divergences from acceptable behavior are detected and publicly reported and also that there are effective means for reasserting democratic control over law enforcement, deterring misbehavior and compensating for injuries that arise as a result of misconduct. That applies, of course, not just to concerns

about policing “on the beat”, but also as to the management and leadership that those in senior positions with police authorities display.

There are, obviously, several different mechanisms that exist to try to accomplish that. First, within the police forces themselves, the mechanisms include peer pressure, managerial control and supervision, disciplinary proceedings, grievance proceedings and police public and media relations communications. Second, most jurisdictions have put in place police complaint investigation procedures. Third, there is the prospect of criminal prosecution and sanctions. Fourth, where death has occurred, there is the prospect of a coroner’s investigation. Fifth, where higher profile incidents attract public attention and result in government commissioning public inquiries, there is the potential for evidence to be obtained in a public forum and a public report result. Those are discussed elsewhere in this book.

If our only concerns were democratic control of law enforcement agencies, or ensuring effective managerial control of law enforcement agencies, we would perhaps stop there. If we could count on those in authority willingly to pay compensation and acknowledge fault where it exists, perhaps we would not need to go further. But concerns about justice for those who are mistreated by the police require that we have available another means of ensuring accountability.

In this Chapter, we will describe a sixth avenue for accountability. It is one that, in many ways, may be said to have deeper historical roots than the others. We will examine it in the context of both wrongful death and personal injury cases, although, as will be seen, the law treats the two differently. The context that we will discuss is the use of the civil law process. Bringing a lawsuit in court against the police or, more usually, the government or police force or authority to which individual police officers belong, has long been a feature of English law.

*Magna Carta* includes provisions that prohibited taking anyone prisoner without authority provided for by law. Later court decisions established independent, impartial courts to try cases and for recognition of civil rights and liberties. Both of those help ensure that police and government power are not unconstrained. Wrongful conduct by government agents interfering with the rights of individuals came to be recognized as making a civil remedy an appropriate response.

Without intending to be exhaustive, the list of civil remedies includes such things as claims for damages for assault, battery, false imprisonment, trespass to chattels or property, defamation, malicious prosecution,



misfeasance in public office, and, in some instances, negligence. Even where no particular tort or cause of action could be identified, the courts allowed that “innominate torts” still might allow for a right of action and redress. Thus, in England in 1703 when a wrong was shown to have been committed by election officials denying an individual his right to vote, Chief Justice Holt dealt with arguments that the *Ashby v. White* case should be dismissed because common law had no known basis for providing a remedy in such circumstances, stating: “If the plaintiff has a right, he must of necessity have a means to vindicate and maintain it, and a remedy if he is injured in the exercise or enjoyment of it, and, indeed it is a vain thing to imagine a right without a remedy; for want of right and want of remedy are reciprocal.”

Later in the 18<sup>th</sup> century, in *Entick v. Carrington* (1765), Lord Camden upheld a jury verdict against government agents who had invaded private property and searched for and seized private papers without any lawful basis for doing so. The government was looking for alleged seditious papers. The use of the civil courts as a means to air the dispute, bring government agents before an independent and impartial tribunal and have a judge and jury order that substantial damages be paid for the violation of the plaintiff’s rights must be regarded as a signal achievement in the development of the law.

In more modern times, in Canada, similar instances of courts holding law enforcement agencies liable for misconduct and violations of individual rights are repeated. We will discuss those in a moment. But before that, we should touch on the general purposes of tort law so that it may be understood in relation to the current topic.

### **The Purposes of Tort Law**

Tort law is part of the common law and civil law of Canada. The word tort arises from old Law French, which both the English and French forbears of the law received and applied during the colonial period in North America used to describe a civil right of action to hold others to account for losses inflicted in circumstances that the law recognized as wrongful. In the 20<sup>th</sup> century there was a great broadening of the scope and importance of tort law with the concepts of generalized duties of care to avoid harm to others. This started as something largely focused upon injuries to persons and property, but later expanded to economic losses.

In two of Canada’s leading texts on tort law, several common themes are described for why we have a civil law providing the means for individuals to seek redress for injuries inflicted on them due to the negligent or intentional wrongful acts of others. Thus, it is generally accepted that tort law aims at:

- a) providing compensation for victims of wrongdoing,
- b) establishing where justice marks the boundary between right and wrongful conduct,
- c) inflicting through court judgments a deterrent effect on those who might engage in wrongful conduct,
- d) providing an opportunity for the parties and the public generally to be educated about what are acceptable, lawful social norms of conduct and what are not,
- e) affording individuals who feel victimized the opportunity to engage an independent and impartial tribunal in hearing their complaints and thus serving an ombudsman-like function, and
- f) addressing the psychological needs of victims to be recognized as having been wronged (Klar, 2008; Linden & Feldthusen, 2006).

Different writers have emphasized different aspects of these as having more or less priority in justifying the existence of tort law. For example, some who touch on deterrence as a purpose of tort law do so because of the moral lessons that defendants found liable for wrongdoing are supposed to learn. Others focus upon the economic effects of having to pay for conduct that entailed risk of harm to others so that the cost of their activities is appropriately borne by those who choose to engage in them.

### **Different Treatment of Claims When Death Results**

While it is noteworthy that there is general agreement on the purposes of tort law in Canada, it is, for present purposes, perhaps more striking that there is another commonality among academics who have studied this area. By that I mean that the leading texts on the subject are full of commentary on the nature of how tort law responds to physical injury, property damage and economic loss, but become mute when the question of death of the victim occurs (Klar, 2008; Linden & Feldthusen, 2006).<sup>2</sup>

That is not intended so much as a criticism as an observation that leading writers on tort law in Canada have largely engaged in descriptive activities concerning the state of the law, rather than engage in a thorough questioning of why the limits of tort law should be demarcated by a line that is drawn if the plaintiff dies, whether as a consequence of the injuries sustained by the defendant's wrongful acts or otherwise.

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<sup>2</sup> The texts of both Klar (2008) and Linden & Feldthusen (2006) lack any entry for wrongful death in their indexes.

The roots of that come from another source of law. First, there is something to history. Prior to the Industrial Revolution, when either the plaintiff or defendant in a cause died, in many instances, the common law regarded the cause of action as coming to an end as well. Some have observed that this was based upon a fallacious assumption made early in English legal history as to the transfer of rights of action upon death. Thus, Fraser, CJA of the Alberta Court of Appeal, wrote in *Ferraiuolo v. Olson* (2004): “What was the rationale for this principle? It was this: a court should not be asked to meet the needs of a person who no longer needed anything because he or she was dead. Loss of life essentially counted for nothing. According to one academic, this principle – which he described as a ‘barbarous rule’ – was based on a misunderstanding of the transmissibility of actions on death under Roman law” (para. 21).<sup>3</sup>

Statute law and developments in the common law came to change some of that, first with regard to situations where the defendant died but where his or her estate could be said to have been improved or benefitted by the property wrongly taken or the injury inflicted on the plaintiff. Later, that was broadened so that defendants were generally liable for the wrongs they inflicted, even after their death. Plaintiffs could pursue their estate for the wrongs done and obtain judgment for compensation for the losses suffered.

That symmetry did not develop in tandem when plaintiffs died. In that situation, the law remained lost in the thought that with the plaintiff gone, there was no point suing. Personal rights of action, the common law maxim asserted, died with the person.<sup>4</sup> Where the infliction of injury involved wrongdoing that could be characterized as criminal, then the state (or where private prosecutions were permitted) would prosecute and the defendant, if convicted, would suffer whatever penalty the criminal law required.

As time passed, that state of affairs was increasingly seen as being unsatisfactory, for obvious reasons. Landed interests and employers suffered a loss when a tenant-farmer or employee was killed. Relatives of the deceased also suffered. But aside from some scattered efforts to have claims for compensation recognized, the law remained without an effective remedy until the 19<sup>th</sup> century. Then, in reforms that paralleled the Industrial

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<sup>3</sup> Fraser, CJA, sets out in a footnote that Goudy (1913, p. 227) states: “If I am right in my reading of the authorities, I think it came into our law owing to the misunderstanding by Bracton of the Roman Law, his inaccurate use of its language, and the consequently erroneous doctrine adopted by Fitzherbert and others...”

<sup>4</sup> Rendered in Latin with the phrase, “Actio personalis moritur cum actor.”

Revolution, the British Parliament passed a set of family compensation laws that allowed for financially dependent spouses and children of deceased persons to sue for compensation. But the compensation was not for the loss of life of the deceased, loss of the earnings or other future opportunities that the deceased may otherwise have enjoyed or for any pain or suffering that he may have suffered. Rather it was just for the financial impact of losing a “breadwinner”.

Canadian law followed through with much of that line of thought. Each of the provinces has family compensation legislation in place that provides for claims by financially dependent persons where their deceased spouse or parent (or occasionally, child) has been wrongfully killed and they have suffered a financial loss. Some have provided for means to circumvent the common law approach barring claims by estates of deceased persons for personal injury losses.

If we pause for a moment, however, and look to the purposes of tort law that have been generally accepted by scholars and jurists for generations, it appears that in the case of deceased persons the law’s response has been inadequate, to say the least. While it may be fairly argued that every one of the purposes would be served by extending tort law to cover cases where someone has died (save perhaps that of providing psychological redress to the victim himself or herself – but even there, psychological redress to the family, friends and relatives of the deceased surely could be considered), as of yet the law’s response in British Columbia and some other jurisdictions has been inadequate.

One need only look to section 59(2) of the *Estate Administration Act*, which provides that “the executor or administrator of a deceased person may continue or bring and maintain an action for all loss or damage to the person or property of the deceased in the same manner and with the same rights and remedies as the deceased would, if living, be entitled to,” but then added a provision saying that right did not include the right to claim for “damages in respect of physical disfigurement or pain or suffering caused to the deceased” or the right to claim for damages “for the loss of expectation of life” or “damages in respect of expectancy of earnings after the death of the deceased that might have been sustained if the deceased had not died.”

The law in other provinces appears to have been interpreted, whether such a provision exists expressly in statute or not, as similarly depriving the personal representatives (executor or administrator of a deceased’s estate) from suing for such claims.

This is not to say that there is no recourse for anyone when a wrongful death occurs. In some instances the law allows the immediate relatives of the deceased to advance a claim. Typically, such claims are limited to the direct financial benefit that the surviving family members can establish that they would have received but for the wrongful death. Some provinces (e.g., Alberta) also provide for damages for bereavement and other more intangible losses. But the concept remains the same – what is the loss that the surviving, living relative has? The loss that the deceased suffered goes uncompensated and unrecognized by the law.

This has been criticized by many. But it is supported by the institutions and by the inertia that often besets an unjust state of affairs. While compensation for wrongful death occasioned by the misconduct of a random individual would likely not cause government or large institutions any significant concern, when one considers the potential effect that having to compensate for wrongful death would require of government, health authorities, motor vehicle and other insurers, one can quickly understand how an array of government and insurance interests would likely oppose reform of this area of law.

That is not to say that reform is impossible to achieve. Examples from the United States are notable. While not consistent across all states, many jurisdictions have provided for either a more effective means of compensating for a wrongful death by liberalizing laws providing for relatives to advance such claims, or by simply abolishing the common law limitation on the personal representatives of the deceased doing so. The fact that such laws exist in a nation whose per capita income exceeds that of Canada suggests that having such laws would hardly bring about serious economic consequences that those who argue against change assert.

If all one is left with is a claim under legislation such as the B.C. *Family Compensation Act*, there is still, of course, the potential for a claim to be brought and the police whose conduct brought about a death to be held accountable. But the damages that may be claimed will be substantial only in instances of the wrongful death of a financially successful person who dies leaving dependents. Thus, where a financially successful person dies without leaving behind any person who qualifies for recognition for making a claim under the *Family Compensation Act*, no claim can be made. And where a person who is not financially successful dies, whether leaving behind dependents who qualify under the *Family Compensation Act* or not, there is either no or no significant compensation that can be awarded and thus the point of bringing a civil action dissipates.

That is, to say the least, something that government and the public shy away from thinking about. The harsh truth is that while Canadian courts have held that for damages for matters of pain, suffering and loss of amenities of life, there should be no necessary distinction between rich and poor, when it comes to providing damages for wrongful death, there is no compensation for which the personal representatives of the poor and marginalized can claim. Their lives are, as has been so poignantly stated by those advocating for reform of the law, “worthless in the eyes of the law.”

Among jurists, this state of affairs often goes unrecognized and without comment. The law is the law and changing it is, so the saying goes, more appropriately done by the legislature than the courts. Yet occasionally one finds such comment. In *Ferraiuolo v. Olson* (2004), the Alberta Court of Appeal dealt with whether the equality and non-discrimination protections of section 15 of the *Canadian Charter of Rights and Freedoms* was offended by Alberta legislation that provided “certain surviving children only – minors and those under 26 who are unmarried and not living with a cohabitant – the right to damages in the sum of \$25,000 for grief and loss of care, guidance and companionship when their parent is killed by a wrongdoer.” The Court held that the *Charter* was violated by that law and struck out the limiting provision, allowing the right to claim for such damages to be made by “each child of the deceased person.” That, obviously, is not a complete remedy to the injustice here. But it was at least some recognition of it.

The words of Alberta’s Chief Justice Fraser on the history of this area of law and the need, from justice’s perspective, for reform, are compelling. We noted earlier her review of the law. She identified that the common law, likely through error and faulty reasoning, had opted for a rule that the personal representatives of a deceased person could not sue for damages for wrongful death. She also observed that at common law there was no sound basis for the courts holding early in the 19<sup>th</sup> century that the survivors of a person wrongfully killed could not sue for damages arising from the death either. She concluded that for all the assumptions made as to the rules against such actions, “none offers a defensible and principled justification for the deficiencies of the common law” (para. 22).

Fraser, CJA, continued by noting the lack of sense in providing for no remedy for wrongful death: “The illogic in asserting that because of the difficulty in valuing a life, the common law will give no value at all to that life is self-evident. Reduced to its simplest terms, that argument amounts to this: ‘Your life is of such great value, if you are wrongfully killed, we will give your estate and your survivors nothing.’ This constitutes the tort equivalent of Marie Antoinette’s ‘Let them eat cake’” (para. 23). The grotesqueness of this situation is aptly captured by this observation: “The

fact it was cheaper for a wrongdoer to kill than to injure explains why some summarized the state of the common law this way: ‘kill, don’t maim’” (para. 31).

As noted above, eventually legislative action was taken. In England in 1846 *Lord Campbell’s Act (The Fatal Accidents Act 1846)* provided for surviving dependents to make claims against a wrongdoer when their near relative was killed. But even that was subjected to odd twists and turns in subsequent court decisions. First, it was restricted to pecuniary claims only – claims for loss of financial support were allowed, claims for intangibles such as grief, loss of guidance, care, companionship and the like were not. In the case of children, however, the law shifted back and forth. Some courts opted to hold that a child’s loss of guidance from a deceased parent was “pecuniary” and so compensable. Others rejected that. Eventually, the law in Canada at least was put on a footing that allowed such claims.

The fact that there continues to be a struggle to try to get the law reformed is a black mark on Canadian law. One may be forgiven for thinking that while the failure to reform may be thought of as being premised on concerns about the financial effects of such measures, the harsh reality is that it amounts to a deprivation of accountability and justice. In the end, if legislatures fail or refuse to act, it may prove necessary for the court to act. The path for doing so in relation to claims against police authorities is perhaps more readily available than for wrongful death claims against private actors. The reason for that is the *Canadian Charter of Rights and Freedoms*. We will address that further when we come to discuss the Supreme Court of Canada’s decision in the case of *Vancouver (City) v. Ward* (2010).

### **Canadian Tort Law and Police Authorities**

While the history of suing the police in Canada for claims of misconduct is perhaps as old as Canada itself, we will take our starting point with a discussion of some of the cases generated in the 1950’s in Quebec, where the police were often too willing helpers of the government in efforts to suppress Jehovah’s Witnesses and other dissident and minority groups.

In *Lamb v. Benoit et al.* (1959), the police had arrested a member of the Jehovah’s Witness group on specious grounds and then sought to have the plaintiff sign a release as a condition of being released. She refused. The police kept her locked up longer and initiated false charges against her, which were later dropped. In the Supreme Court of Canada, Locke, J., held that “The appellant was subjected to the ignominy of arrest and prosecution for the offence of distributing a seditious libel, of which offence Benoit knew from the outset she was innocent. She incurred liability to counsel

who appeared on her behalf at the trial in the amount of \$150. I would award damages against Benoit of \$2,500 and costs throughout.” Rand, J., agreed, saying, “the case is one for substantial damages...”

A similar case was *Chaput v. Romain* (1955), where the facts were that “members of the provincial police, broke up an admittedly orderly religious meeting conducted by a minister of Jehovah's Witnesses in the appellant's house, seized a Bible, some hymn books and a number of booklets on religious subjects, and ordered those present to disperse. The entry and the seizure were made without a warrant. No charge was at any time laid against any of the participants including the appellant and the items seized were not returned.” In the Supreme Court of Canada, Taschereau, J., wrote that the plaintiff had suffered moral damages, not financial ones, but was nonetheless entitled to compensation for the interference with her rights. Rand and Kellock, JJ., agreed, holding that “he is entitled to recover ‘moral’ damages, a term, which, for present purposes, may be said to be analogous to ‘general’ damages in the common law.”

The damages awarded by the court were modest. They agreed on \$2,000. Locke, J., concurred in the result, but said he thought “the damages should be assessed at a higher amount.” Of course, \$2,000 in the 1950's would compare with a sum at least eight times as great in current dollars.

In more recent times, police and other law enforcement agencies have been held accountable in civil cases for a variety of wrongs.

Thus, in *Uni-Jet Industrial Pipe Ltd. v. Canada (Attorney General)* (2001), the government was held liable for \$65,000 in damages to a company and its principal for an RCMP officer's tip to media of the impending execution of a search warrant. The officer knew that the tip violated RCMP policy concerning publicity in such circumstances and that the tip would also be likely to cause damage to the plaintiff. Charges were never laid. The plaintiff was cleared of the allegations made (fraud in relation to construction of sewage facilities). The damages awarded included compensation for the plaintiff's injury to reputation and loss of goodwill, and also included punitive damages to show the court's disapproval of the conduct involved.

A more curious case was dealt with in the Federal Court in *McMaster v. Canada* (2009). Mandamin, J., upheld a finding of liability for \$6,000 damages for prison officials who failed to observe a prison regulation to provide safe footwear for inmates. The evidence showed that the inmate suffered an injury to his foot from what were known by officials for a considerable time to be ill-fitting shoes. Prison regulations set a standard that required that inmates be supplied with proper footwear. While perhaps



odd in its particulars, the principles involved in the case are ones of general application. Where a standard exists, it is not for individual police or prison officials to decide not to adhere to it. Where rights are violated, the courts exist to hear the complaint and provide a remedy.

In cases of wrongful arrest, there are many claims brought, although given protections provided for the police in statute fewer end up being successful. This is not because of the presumptions of law that have to be made. As was ably discussed by Ehrcke, PCJ, in *Woods v. Vancouver (City)* (2009), “the defendants bear the onus of showing their conduct was justified: *Mann v. Balaban*, [1970] S.C.R. 74. The same holds true for false imprisonment – once there is an imprisonment, the defendant bears the onus of proving it was justified: *Frey v. Fedoruk* [1950] S.C.J. No 21, p. 5” (para. 58). Rather, it is because statute has provided for what lawful use of force may be employed by the police, when arrests and detention are lawful and when someone arrested or detained may be imprisoned. Thus, for example, section 25 of the *Criminal Code* provides for what is justified conduct on the part of the police. It provides that so long as a police officer has “reasonable grounds”, he may use such force as is necessary to do what he is legally authorized or required to do.

Ehrcke, PCJ, provides a convenient summary of three questions that must be asked and answered in order to establish whether police are protected by the *Criminal Code*:

- a) Were the police authorized or required by law to perform an act in the administration or enforcement of the law?
- b) Did the police officers act on reasonable grounds?
- c) Did the police use unnecessary or excessive force? (paras 62-71).

The Judge continued with his review of the law and noted that although the police bore the burden of proof in showing that their conduct was justified, there was in the case law still a fair degree of deference and latitude afforded them: “The police must prove each of the three elements on a balance of probabilities. In assessing the police behaviour, the court must determine whether, given the circumstances faced by the officer, the officer had an objectively reasonable basis for what he or she did: *Berntt v. Vancouver (City)* (1999). The police must be given some latitude: *Crampton v. Walton* (2005) (at para. 22). Likewise, the police are not expected to gauge precisely how much force is necessary, or use the least amount of force required; allowance must be made for the exigencies of the moment: *Crampton* (at para 45), in which numerous other cases are cited. The police actions should not be assessed through the “lens of hindsight”: *Robinow v. Vancouver (City)* (2003, para. 71).

In the result in the *Woods* case, Ehrcke, PCJ, found that, even after allowing for the latitude and deference that case law set out, the officers involved failed all three questions. He then considered whether the *Police Act* of British Columbia provided them with a defence. Section 21 of that statute provides for immunity for the police from suit for actions done in the performance or intended performance of their duties, save for where it is shown that they engaged in “dishonesty, gross negligence or malicious or willful misconduct...”

Again, the rationale for this kind of law is that the police need some standard for civil liability higher than merely showing an error in judgment. Thus, the police enjoy, both from statute and from the regard that they have in the courts, a position where they obtain a degree of deference for their actions. But, as the *Woods* case and others show, that deference is not unlimited. In the *Woods* case, the court ordered that the police pay \$13,000 in damages for the wrongful arrest and detention of the plaintiff.

### **Three Recent Notable Supreme Court of Canada Decisions Affecting Police Civil Liability**

Three comparatively recent decisions by the Supreme Court of Canada, decided over the last seven years, bear mention here. They are *Odhavji Estate v. Woodhouse* (2003), *Hill v. Hamilton-Wentworth Regional Police Services Board* (2007) and *Vancouver (City) v. Ward* (2010).

In the *Odhavji* case, the Court defined and applied the tort of misfeasance in public office and negligence to a case brought by the family of a person who was fatally shot by the police. The case involved a determination whether the pleadings adequately described a claim that the law would recognize. The Court allowed the claims to proceed to trial and refused to strike out the action. The court discussed the standard for establishing misfeasance. Iacobucci, J., wrote (at para. 22), that there were two basic categories of misfeasance that the law recognized: “Category A involves conduct that is specifically intended to injure a person or class of persons. Category B involves a public officer who acts with knowledge both that she or he has no power to do the act complained of and that the act is likely to injure the plaintiff.”

He elaborated on what was required to be proven (at para. 23) as follows:

First, the public officer must have engaged in deliberate and unlawful conduct in his or her capacity as a public officer. Second, the public officer must have been aware both that his or her conduct was unlawful and that it was likely to harm the plaintiff....In Category B, the plaintiff must prove the two ingredients of the tort independently

of one another. In Category A, the fact that the public officer has acted for the express purpose of harming the plaintiff is sufficient to satisfy each ingredient of the tort, owing to the fact that a public officer does not have the authority to exercise his or her powers for an improper purpose...

In the *Hill v. Hamilton-Wentworth* case, the case report notes that the plaintiff alleged that he was “investigated by the police, arrested, tried, wrongfully convicted, and ultimately acquitted after spending more than 20 months in jail for a crime he did not commit.” He asserted that negligent police investigation had led to all of the difficulties he suffered and sought compensation. Over the opposition of arguments presented for the police officers and agencies involved, the court upheld the concept of the law of negligence applying to police investigations. But in the result, the court held that measured by the standards of appropriate police investigation at the time of the events in question, the police had not been negligent, notwithstanding the admittedly botched investigation and the unfair incarceration of the plaintiff.

Chief Justice McLachlin wrote that accountability of law enforcement officers through the civil justice system was an important feature of Canadian law: “Police are not immune from liability under the Canadian law of negligence, ... police owe a duty of care in negligence to suspects being investigated, and ... their conduct during the course of an investigation should be measured against the standard of how a reasonable officer in like circumstances would have acted. The tort of negligent investigation exists in Canada...” (para. 3).

The majority was alive to the consequences of negligent investigations: “existing remedies for wrongful prosecution and conviction are incomplete and may leave a victim of negligent police investigation without legal recourse. The torts of false arrest, false imprisonment and malicious prosecution do not provide an adequate remedy for negligent acts” (para. 35).

Those considerations obviously spilled over into whether there was any policy reason to negate the prima facie duty of care. McLachlin, CJC, found none: “A prima facie duty of care will be negated only when the conflict, considered together with other relevant policy considerations, gives rise to a real potential for negative policy consequences. This reflects the view that a duty of care in tort law should not be denied on speculative grounds” (para. 43).

On the question of whether there would be a chilling effect from recognizing the tort of negligent investigation, she added: “In theory, it is

conceivable that police might become more careful in conducting investigations if a duty of care in tort is recognized. However, this is not necessarily a bad thing.” Given that negligent performance of their duties will, in almost all instances, be something for which public authorities will be vicariously liable, the notion of a chilling effect seems unlikely. Negligent job performance already is something that could lead to poor reviews and possible internal disciplinary proceedings; adding the potential for civil liability for which the police authority will be liable merely broadens the public aspect of that.

*Hill v. Hamilton-Wentworth* has been subjected to academic criticism, not for going too far, but rather in not going far enough. Professor Chamberlain argues that the “deferential” standard of care adopted by the Court may deprive the tort of negligent investigation of much of its utility: “If the lower courts follow the Supreme Court’s lead, plaintiffs will only be successful in the most obvious cases of police negligence. Further, given the importance of loyalty and mutual support within the profession, there is reason to be skeptical whether police will be willing to testify that a fellow officer’s conduct fell below the standard of care” (Chamberlain, 2008, para. 34).<sup>5</sup>

Professors Clarke and Whitt (2008) have compared American and Canadian experiences with wrongful convictions. They suggest that the fact that Canada has put in place a negligence standard of civil liability for police practices will be beneficial: “This rule requiring substantial police accountability in Canada will almost certainly result in proportionately fewer wrongful convictions in Canada than in the United States” (Clarke & Whitt, 2008, p. 619, fn. 1). Canada’s approach is contrasted with that of the US, saying “This is far more liberal than the U.S. practice that grants the police qualified immunity for their discretionary acts and shields them from liability for civil damages insofar as their conduct does not violate ‘clearly established’ statutory or constitutional rights of which a reasonable person would have known” (p. 619, fn. 1).

In the case of *Ward v. Vancouver (City)*, the Court dealt with an appeal by a city that had been held liable for \$5,000 in damages for a violation of the plaintiff’s *Charter* rights arising from the Vancouver police having wrongfully arrested, strip searched and detained the plaintiff. The Court agreed that a civil claim could be made under section 24 of the *Charter of Rights and*

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<sup>5</sup> See also: Negligent Investigation: The End of Malicious Prosecution in Canada? (Chamberlain, 2008).

*Freedoms* in appropriate cases such that compensation could be ordered for violation of protected constitutional rights.

Chief Justice McLachlin explained the basis for that at para. 25, “For damages to be awarded, they must further the general objects of the *Charter*. This reflects itself in three interrelated functions that damages may serve. The function of *compensation*, usually the most prominent function, recognizes that breach of an individual’s *Charter* rights may cause personal loss which should be remedied. The function of *vindication* recognizes that *Charter* rights must be maintained, and cannot be allowed to be whittled away by attrition. Finally, the function of *deterrence* recognizes that damages may serve to deter future breaches by state actors.” The concurrence of those purposes underlying *Charter* damages with the purposes of tort law described at the outset of this chapter is notable.

Earlier, we noted the difficulties the law has had with the concept of a deceased person’s personal representatives advancing a claim for wrongful death. The *Charter of Rights and Freedoms* provides protection for us all in section 7 as follows: “Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.” No one could seriously argue that a wrongful deprivation of life brought about by the police does not engage this provision. Providing damages for such a wrong would achieve all of the goals that McLachlin, CJC, identified in *Ward*. Failing to do so suffers from all the faulty logic and lack of justice that Fraser, CJA, identified in *Ferraiuolo v. Olson*. Some may argue that once dead there is no “individual” left to assert breach of a *Charter* right. But to accede to that argument would mean that none of the purposes of the *Charter* would be served.

### **Discovery in the Civil Litigation Process**

One of the advantages of the civil litigation process that dovetails with certain aspects of the accountability principle is that of obtaining discovery. Discovery means having the right to obtain information from one’s opponent in a civil case prior to trial by means of requiring that documents material to the issues in dispute be produced for inspection and copying and by means of requiring that the opponent attend an examination for questioning on those issues. Civil litigation is a process that, by any measure, achieves a great deal of efficiency through rules that aim at focusing the parties on what the facts and legal basis for their claims and defences are and then forcing them to disclose through discovery most all of what their evidence at trial will be. The fact that civil litigation results in

settlements or abandonments of claims in 95-98% of all cases may be said to result largely from these channeling rules.

This has two consequences, at least, for the present topic. First, the existence of discovery rights under the rules of court applicable to civil litigation in superior courts in Canada affords persons whose rights and interests have allegedly been violated by police misconduct to get at information that might otherwise not have been disclosed. Thus, the claimant can ascertain whether internal to the police force there were reports or reviews of the incident giving rise to the claim or the officer's conduct that either assist in proving his or her case or that set out information that is likely to assist the police in successfully defending the case. Either way, of course, the claimant gains the benefit of knowing what it is that the police have to say. That is an elementary aspect of accountability.

There are constraints on this and on its utility that must be mentioned. While enjoying discovery rights is a definite positive for the claimant, the civil law process imposes an obligation of confidentiality on documents and information obtained through the discovery process. Because it is civil litigation, it is taken to have a private law aspect that the courts have come to accept means that certain rules as to privacy must be imposed.<sup>6</sup> The courts have explained why there is a distinction between this rule of confidentiality as to pre-trial processes and the "open court" rule allowing public access at trials as follows: "Pre-trial discovery does not take place in open court. The vast majority of civil cases never go to trial. Documents are inspected or exchanged by counsel at a place of their own choosing. In general, oral discovery is not conducted in front of a judge. The only point at which the 'open court' principle is engaged is when, if at all, the case goes to trial and the discovered party's documents or answers from the discovery transcripts are introduced as part of the case at trial" *Juman v. Doucette* (2008, para. 21).

This feature can make civil litigation that does not go to trial or otherwise involve a court hearing that provides for disclosure of the information that has been discovered less useful in relation to the aspects of the accountability principle that involve public disclosure of information.

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<sup>6</sup> On this point, generally, see *Lac d'Amiante du Québec Ltée v. 2858-0702 Québec Inc.*, 2001 SCC 51.

Similarly, the likelihood that cases brought in civil court will end up being settled or abandoned also detracts from its utility in serving the public disclosure aspects of accountability.

Finally, many cases involving claims of police misconduct are unlikely to achieve the threshold between small claims court jurisdiction (currently \$25,000 in British Columbia) and that of the superior courts. While superior courts afford comparatively generous discovery rules to litigants in order to allow a more comprehensive threshing out of issues prior to trial, small claims courts tend in the opposite direction. Thus, there is no generalized right to demand discovery prior to a judicial hearing in small claims court litigation. Instead, the parties are allowed to apply for a court order to that effect or, more customarily, to make such a request at the settlement conference/pre-hearing conference that is mandatory in small claims court. Having said that, there is no guarantee that the court will accede to a request that an order be granted requiring an opponent to produce documents.

Notwithstanding the potential limitation that may exist by proceeding in small claims court where the amount involved is modest, small claims court offers litigants the opportunity to confront witnesses produced by one's opponent by way of cross-examination. This fundamental feature of natural justice exists as well in the superior courts at trial. The great American legal scholar John Henry Wigmore, whose texts on evidence are known throughout the world and have often been referred to in Canadian courts, once wrote that "Cross-examination is the greatest legal engine ever invented for the discovery of truth." That is true not just for the fact that in cross-examination one may put inconvenient facts to an adverse witness and seek thereby either to obtain an admission or to demonstrate just how incredible the witness is. It is also so because of the fact that in a relationship that starts off as one of a clear power imbalance – police authority vs. individual – the right to cross-examine affords the less powerful with the means of testing the more powerful in a setting where the "truth" ceases to be something defined by power and instead becomes something defined by what is proven.

## **Conclusion**

Civil litigation and the tort system have long afforded people with the means of seeking redress for wrongs done in a process designed to ensure that there could be a full and fair airing of the issues in dispute and, if the parties did not otherwise settle or abandon the claims, have them adjudicated before an independent and impartial tribunal that was charged with fully and fairly hearing all admissible evidence, making appropriate

findings of fact, applying the law and then pronouncing a judgment accordingly. The civil litigation process and tort law have definite advantages in empowering many would-be claimants with an opportunity to initiate a legal process that offers the potential of providing accountability on the part of the persons or agencies who have harmed them. While it may not be perfect and may not yet have available as recognized causes of action claims that would fully vindicate wrongful death, ongoing litigation may yet change that. Where the facts of the case involve claims by a living victim of wrongful conduct for substantial damages may fairly be seen to exist, civil litigation is a useful means of achieving accountability.



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# **Overcoming Barriers: Changing Our Approach to Police-Involved Deaths**

David MacAlister

## **Need for reform**

Canada is an advanced democracy with a deep concern for fundamental rights and freedoms. It has long recognized the supremacy of the rule of law and the importance of subjecting limits on the powers of government to intrude into the rights and liberties of individuals. Accordingly, it comes as no surprise that police-involved deaths have attracted considerable media and public attention in recent years. Few issues involving the conduct of government are of such significance as those arising in this context. In order for the government and its agencies to maintain legitimacy, there must be ongoing respect for fundamental rights and a willingness to facilitate clear and effective oversight if they are to maintain public confidence in the government in general, the criminal justice system more particularly, and especially in the police. The police rely on public support in order to fulfil their mandate. A society in which the police fail to secure public support will find it impossible to effectively fulfil their role.

The recent spate of police-involved deaths, particularly those arising in western Canada, has caused a crisis of confidence in the police. There is much that needs to be done in regard to setting out a plan for a future in which the number of police-involved deaths are minimized and the police are aided in moving forward to a position in society in which they are respected and trusted.

## **Collecting Data**

Despite the important nature of the phenomenon, and considerable public concern over the matter, very little is known about deaths in police custody in Canada. What little is known comes out inconsistently from a variety of sources. A major effort by the B.C. Civil Liberties Association (2010) to ascertain information regarding the extent of the phenomenon was frustrated by a lack of cooperation from many chief coroners across the country. Alberta, Manitoba, Quebec, Nova Scotia, Prince Edward Island,

and Newfoundland and Labrador failed to provide the BCCLA with any information regarding police-involved deaths in their jurisdictions. Several other jurisdictions only provided cursory information, making it impossible to generate a national picture of the phenomenon.

In the UK, the NGO INQUEST has been instrumental in carrying out a research agenda that looks at the nature and extent of deaths-in-custody in that country. Amnesty International has attempted to keep an eye on the nature and extent of human rights abuses around the world, but does not have the resources to collect data on this topic in Canada. In the US, the Bureau of Justice Statistics has begun compiling statistics on deaths in custody on a regular basis (see: Mumola, 2007) as a result of a legal mandate from Congress, which enacted the *Death in Custody Reporting Act of 2000*. Canada has failed to mandate a similar reporting structure.

The need for data on police-involved deaths is necessary to garner an accurate picture of the nature and extent of the matter. Canada's Aboriginal population is understandably aware anecdotally that they are at high risk of dying through police contact. This is what led the First Nations Summit Chiefs in Assembly to begin inquiring into the nature and extent of police-involved deaths of Aboriginal people in 2003, culminating in the preliminary report by Hannum (2003). That report lamented the sad state of data gathering on this topic in Canada, leaving Aboriginal groups frustrated with the lack of information on the topic. The lack of race-based statistics has also been identified as a cause for concern by Scot Wortley in his report prepared for the Ipperwash Inquiry:

Canadian research on police violence has been greatly hindered by the fact that police services in this country *do not* routinely release official statistics on police shootings or other use of force incidents. Moreover, research on racial differences in police use of force is almost impossible to conduct because there is an informal ban on the release of any type of information that breaks down criminal justice statistics – including police shootings – by civilian racial background (Wortley, 2006, p. 6).

The need to gather race-based statistics has been the subject of considerable controversy in Canada. The gathering of race-related justice statistics fell into disfavour in Canada in the 1990s; however, more recently there have been calls to keep such statistics in order to ascertain the extent to which discrimination arises in the justice system (see: Cheema, 2009; Owusu-Bempah & Millar, 2010).

There is a clear need for comprehensive data collection on police-involved deaths in Canada. A full understanding of the phenomenon is necessary if we are to understand how to best tackle the problem. A nationally mandated data collection and publication program appears to be the logical solution to this problem. Regardless of what the data reveal, there has been a clearly documented move towards increasing police transparency and accountability for police-involved deaths. However, over the years there has been considerable resistance amongst police agencies to calls for reform that may have an impact on reducing the numbers of police-involved deaths.

### **Battling the Police Establishment**

An essential element of police accountability is external, civilian-led investigations of alleged serious police wrongdoing. Most of the resistance to independent investigation of the police appears to come from the police themselves. Over the years, line level police officers and senior police management have frequently advanced arguments favouring the retention of a system in which the police continue to investigate the police, thereby ensuring allegations of police wrongdoing will be investigated by fellow police officers. From their viewpoint, this appears to take the preferred form of the police organization policing itself, and in modified form, it involves fellow police officers from a neighbouring jurisdiction conducting the investigation. Those seeking to retain police investigating the police approaches may reluctantly concede to external investigation by a civilian-led agency, but only if the investigators are working police officers, seconded from police agencies. Less desirable, in their eyes, is a civilian agency in which former police officers, usually retired, conduct the investigations. However, each of these approaches is viewed by many police officers as vastly superior to a scheme whereby civilian police officers with no policing background carry out the investigation of alleged police wrongdoing. They also appear to adopt an approach that emphasizes the rights of the accused officer to be presumed innocent, and call for a heavy burden to prevail on their accusers to establish wrongdoing. These are in marked contrast to the views expressed by many police officers regarding the recognition of such rights for accused persons who are not police officers, facing prosecution in the criminal courts.

### **Police Arguments for the Status Quo**

Among the various arguments advanced by the police for maintaining the prevailing system of self investigation are the following:

## **1. Are Police the Only Competent Investigators?**

A familiar line of argument against the use of non-police civilian investigators of alleged police wrongdoing is that non-police officers are not competent to carry out the investigation. It is frequently asserted that only police officers with many years of investigative experience have the necessary knowledge, skills and abilities to conduct a competent major crime investigation. Even junior police officers without extensive investigative experience would not be trusted with such a task. The investigation of a police-involved death is a homicide investigation. It requires the years of skill and expertise developed by a major crime detective to carry out a proper investigation. It has been claimed that the stakes involved in these investigations are so high that they cannot be trusted to what the police perceive to be amateur investigators. It is argued that it takes years for a major crime investigator to become really good at what he or she does. The skills are not of a nature that can be picked up quickly or learned as one goes along. Police often argue that no other segment of the population is involved in investigations of this nature. Accordingly, it is not possible to find civilian investigators with the skill set needed to carry out a complex criminal investigation.

Proponents of the status quo argue the necessary skills cannot be adequately attained outside the training and experience applicable to police agencies. Only a handful of police officers in each police department are responsible for conducting serious crime investigations. Even among senior police personnel, many believe they could not walk into the role of serious crime investigator without considerable training. Since police officers are experienced investigators themselves, they are unlikely to stand for incompetent investigations being carried out against them. Knowledge of the job is an essential prerequisite to being a good investigator. Unless the investigator has spent time as a police officer, they will not have an adequate appreciation of the job to have enough insight to determine whether something went wrong. If a bridge collapsed and one wanted to conduct an inquiry into whether the bridge's engineer was responsible for generating a design flaw resulting in the collapse, it would not make sense to hire a plumber or an electrician to investigate whether something was done wrong. It would be logical to call upon another bridge engineer to look at the plans for the bridge and to inquire into the methods and materials called upon to construct the bridge. Similarly, many police officers believe that if a police incident has resulted in harm to a civilian, it only makes sense to call upon those most familiar with the policing role to look into whether something was done wrong.



The validity of this claim is open to serious doubt. All police officers are recruited for being intelligent problem-solvers; however, beyond this, there is nothing special about the kinds of people recruited into policing that makes them inherently better investigators than others. Police investigators become good at what they do through training and experience. This is something that can be done with investigators who do not come from a police background. Additionally, as Gareth Jones has noted elsewhere in this volume, the typical police wrongdoing case is much simpler than the typical case encountered by serious crime investigators working in police agencies. Investigating police-involved deaths is not a “who done it”. For the typical major crime investigator, the biggest problem is often figuring out who committed the crime. In police wrongdoing cases, the officer alleged to have hurt or killed another is usually very easy to identify. These cases are usually well documented, and there are often numerous police witnesses available to interview for the purposes of the investigation.<sup>1</sup> Establishing a legislative scheme that compels police to cooperate with external investigations is essential given police reluctance to subject themselves to external investigation (see Marin, 2008).

## **2. Is Self Policing Necessary to Reflect Professionalization?**

Police in western democracies often see themselves as part of a profession. Part of their resistance to civilian investigation of the police is a view that self-policing is an essential component of their professionalization. It may be asserted that other professions, such as medical doctors and lawyers, employ oversight mechanisms that include investigations of allegations of wrongdoing carried out by members of the profession itself. Professional associations, such as the Law Society for lawyers and the College of Physicians and Surgeons for medical doctors are believed to be made up of members of these professions, and these are believed to be the people who carry out the investigation, and in some cases, the adjudication and punishment of alleged wrongdoing.

The process of investigating alleged wrongdoing in differing professions varies widely. Medical doctors who are alleged to have committed wrongdoing in B.C. are subject to an investigation by the College of Physicians and Surgeons. A staff person with the college collects pertinent information which goes forward to an Inquiry Committee. That committee reviews the information that has been gathered, and may interview

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<sup>1</sup> However, the recent case involving the SIU’s investigation into the injury of Dorion Barton by a member of Toronto’s police force during the G20 summit in Toronto in 2010 reveals that some external investigation cases turn on identifying the officer involved (Mahoney, 2011).

witnesses itself before deciding on a course of conduct. The committee is not wholly composed of medical doctors. There are always non-physicians with various areas of expertise on these committees in addition to physicians. If a complainant is not satisfied with the findings of the committee, they may appeal to a Health Profession Review Board which is chaired by a lawyer and composed of non-physicians appointed by the provincial government.

Members of the legal profession in B.C. are investigated for alleged wrongdoing by staff working for the Law Society. The investigating staff are varied in their backgrounds, and include forensic accountants and former police officers in addition to lawyers. If the incident is believed to warrant invoking the discipline process, the case is brought before a Discipline Committee of the Law Society. That committee is made up of Benchers, who are lawyers elected by the profession, and possibly other practicing lawyers; however, at least one member of the discipline committee must be a Lay-Bencher, a non-lawyer appointed by the province to the governing body of the Law Society.

In any profession, the mechanisms set up for the investigation of alleged professional wrongdoing usually apply to a wide range of conduct. However, serious wrongdoing will almost invariably result in an external investigation carried out by the police. Accordingly, it may be appropriate for minor acts of wrongdoing to remain within the control of internal affairs or professional standards units within a police agency, yet it is not necessarily logical to assume that serious wrongdoing should also be carried out by that same police force. When the alleged serious wrongdoing is done at the hands of a police officer, it calls for an external investigation to avoid the appearance of the police taking care of one another through less than vigilant investigations.

For the police to equate their quest for professionalization as a desire to place themselves on the same footing as doctors and lawyers is to ignore fundamental differences in the roles being fulfilled. It has been asserted that it is “dangerous” for the police to argue in favour of the same degree of self-regulation and autonomy enjoyed by other professions (Cordner & Sheehan, 1999). Police occupy a unique role in a democratic society. “The tendency of the police to hide behind the cloak of professionalization as a means of escaping public scrutiny and avoiding accountability to the public has some frightening aspects” (Cordner & Sheehan, 1999, p. 435).

### **3. Does Independent Investigation Send a Message Police Can't Be Trusted?**

Some police officers appear to be concerned that surrendering investigations to an outside agency sends a message to the public that the police cannot be trusted. If you cannot police yourself, then who can you police? An outside agency coming into a police department to conduct an investigation into alleged police wrongdoing may not be particularly confidence inspiring to the general public. It compels one to draw comparisons to the FBI investigating police-involved murders of blacks during the civil rights movement in the US, and the Mexican army having to step in to take control of Tijuana after many local police officers were found to be involved in the local drug wars. It could be argued that taking investigations of alleged police wrongdoing out of the hands of police investigators and placing them under the control of an external agency may send a message that the police should not be trusted to carry out any investigations at all.

A contrary argument is that police can be trusted when they maintain transparency and accountability through a legitimate accountability structure. Principles of democratic governance imply that more harm flows from a police force maintaining control over self-investigation than flows from placing the responsibility for investigating wrongdoing in the hands of an external agency. The police in British Columbia have done a terrible job of maintaining the public trust in recent years. Instances of police abuse of authority, internal corruption, misinforming the public, and applying a double standard that has seen many police officers escape accountability for alleged wrongdoing have done more to harm the reputation of the police than taking away their capacity to self-police is likely to cause. It can be expected that public respect and trust in the police will increase once a regime of transparency and accountability is in effect.

### **4. Will External Investigation Foster a Culture in Which Police Become Less Ethical?**

It may be claimed that taking investigations out of the hands of the agency responsible for the wrongdoing divests that agency of the responsibility to remain ethical. The current Police Ombudsman for Northern Ireland asserts: "oversight systems, in some cases, cause police to abdicate their own responsibility to self-regulate conduct and maintain public trust and confidence..." (Hutchinson, 2005, p. 6). His claim is that police need to retain the responsibility to self-regulate their behaviour since involvement is key to maintaining integrity. The creation of an external oversight mechanism has the undesired effect of diminishing self-control, thereby

contributing unethical conduct through diminishing the commitment of officers to their force's integrity.

Being invested in one's job likely has a positive effect in overall performance, including maintaining ethical conduct. However, it is difficult to envision how adding a layer of accountability will, in itself, lead to a decrease in ethical conduct. Commitment to an organization should be fostered through effective leadership as reflected in proper organizational management and administration, not by putting the police in charge of policing themselves. Even Hutchinson acknowledges that self-policing is incapable of maintaining public trust on its own. Public trust requires "trust assurance measures" brought about through accountability via external agencies (Hutchinson, 2005, p. 6).

Having a vigorous oversight process in place may have a deterrent impact on wrongful police conduct. If police believe their improper actions are likely to be critically investigated, it is arguable that they will be deterred from engaging in wrongdoing.

## **5. Does Excessive Oversight Have a Dampening Effect on Effective Police Practice?**

Some police officers are concerned that subjecting their actions to excessive scrutiny may have an inhibiting effect on their ability to properly do the job. If a police officer is overly concerned that every action will be placed under a microscope, they may be reluctant to take action where it is necessary to properly fulfil their policing responsibilities. Embracing a system of vigorous civilian investigation by investigators without an appreciation for the challenges of police work may have the unintended consequence of inhibiting decisive, effective police responses in crisis situations. Police may take the safe approach to problems by choosing inaction over action, perhaps resulting in placing lives or property in jeopardy.

There may be little merit in this argument. Police are used to working in an environment where their decision-making is subjected to after-the-fact scrutiny. Police officers are routinely accountable to their supervisors for decisions they make in the field on the spur of the moment, and they are also routinely held accountable for their exercise of discretion by the courts. Police must justify their requests for warrants, and will inevitably have to explain their decisions to detain, to arrest, to carry out a search, or to use any of the many police powers they have been accorded, especially if the cases they are investigating end up coming to court. Illegally obtained evidence is often excluded from trials, and the police always operate under the knowledge that they may be held civilly liable for failing to meet the standard of care expected of them.

If the police change their practices so as to think twice before exercising their considerable powers, we should not consider this to be a negative outcome. It is actually the desired outcome of an effective system of police oversight. The repercussions of the decisions made by the police can be so profound and life changing for those with whom they come into contact that we would hope the police exercise caution before making decisions. If they are confident in their training, they should welcome having their decision-making reviewed by an impartial third party rather than seeking to hide behind a veil of secrecy. The rule of law requires that the police be subjected to impartial scrutiny the same as they believe they scrutinize the lives of those whom they investigate.

### *Police Subculture & Police Personality as Barriers to Reform*

As a group, police officers have been found to work within an occupational subculture that has its own norms, values and other characteristics that are fairly unique. Like many occupational groups, the police are a conservative group that is resistant to change. They are also a group composed of individuals with a like-minded world-view that has been the source of considerable problems when it comes to openness and transparency. This subculture and working personality may serve as a hindrance to the development of open and transparent accountability methods for dealing with deaths in police custody.

The academic literature has pointed to a number of common characteristics among police agencies and the officers working within them. Some notable attributes of the police subculture are the following:

1. Social isolation – police officers tend to socialize with one another, providing each other with mutual support.
2. Perception of the public as hostile – the police often view the public as unappreciative of their efforts.
3. Informal code of conduct – secrecy and loyalty to one another are expected of police officers, and reinforced through informal mechanisms.
4. Working personality – police officers adopt a self-identity that moulds and shapes the personality of individual officers, affecting their world view and guiding their interactions with others (MacAlister, 2004).

These aspects of the police subculture have a clear impact on individual officers and the police organization. One of the most profound impacts of

the police subculture is their desire to remain cloistered from society at large, to look after one another, and to resist anything that is perceived as threatening:

Insulation from the public, from the rest of officialdom, and from other police agencies may enhance group loyalty and esprit de corps, both of which are desirable. But insularity also may breed abuse, violence, and secrecy. When insularity exists in an agency headed by a charismatic chief executive who has managed to move beyond accountability, police mistreatment, excessive force, and secrecy have proved virtually inevitable (Skolnick and Fyfe, 1993, p. 134).

Police culture has been acknowledged as a major impediment to the investigation of alleged police wrongdoing (Kappeler, Sluder & Alpert, 1998), particularly in light of the “wall of silence” that accompanies the culture (Skolnick, 2002). The emphasis on loyalty found within the informal police code leads to a tendency among police officers to cover for one another, to refuse to report misconduct, or to falsely claim absence of knowledge of any misconduct. Herman Goldstein has identified the police subculture as one of the major impediments to effective police reform, arguing that any change must seek to “reduce the factors that contribute to the strength of the police subculture” if the reforms are to be effective (Goldstein, 1990, p. 30). He notes that police are likely to be highly resistant to change in their day-to-day practices.

Police organizations appear to be very resistant to change. The police subculture itself tends to be very conservative and resistant to change. This attribute of police organizations prevails in both line-level police subculture and police management subculture. Historically, elevation within police organizations to the higher ranks was strongly linked to length of service rather than educational achievement or demonstrated leadership ability. Accordingly, it has been those individuals who have been well socialized into the police subculture who have taken on management-level positions in police organizations. Similarly, many police organizations historically identified and promoted individuals to the senior ranks from within the police organization rather than shopping externally for top management personnel. In almost all police agencies where senior police managers have been recruited from outside the ranks of the department, the line level officers have actively resisted those individuals, particularly where they have chosen to make significant changes within the organization.

The tendency to promote long-serving members from within the police organization naturally leads to organizations that are characterized by stability and resistance to change rather than taking a change-oriented

progressive approach to police management. This may make it difficult to effect significant change within police organizations as both the line level culture and the management level culture are resistant to change, particularly where that change seeks to break down longstanding values of solidarity and loyalty.

Police unions typically advocate for the rights of police workers and help to maximize salaries and improve working conditions for the employees they represent. In Canada, and particularly in British Columbia, the unions representing municipal police officers have been very active in resisting any progressive changes to police oversight and accountability mechanisms. For example, the head of the local Vancouver police union, Tom Stamatakis, has argued that the six police officers who rounded up three individuals off the streets of Vancouver in 2003 and ultimately beat them in Stanley Park should not lose their jobs (Armstrong, 2004). The Chief ultimately dismissed two of the officers. A proposal to institute “integrity testing” by setting up undercover scenarios in which Vancouver police officers would be tempted to engage in corrupt practices was also strongly criticised by the police union (Smith, 2004). Stamatakis has also gone on record as opposing the use of polygraphs to determine whether police who are under investigation for alleged wrongdoing are telling the truth (Ferry, 2009). At a recent public forum on police accountability (Nov. 30, 2009), Stamatakis spoke out against using civilians to investigate serious police wrongdoing. His concern centred on the assertion that only the police are competent to carry out such serious investigations. His concern continued through 2010 (Lupick, 2010); however, after meeting with incoming Premier Christy Clark just prior to the announcement of the creation of a civilian investigative body for police in B.C., Stamatakis appeared to change his tune and appeared with Clark at the press conference announcing the new Independent Investigations Office (Howell, 2011).

The police constitute a powerful lobby group that seeks to have its interests protected through law and policy. Members of the B.C. Police Association, a group representing municipal police officers throughout B.C., and headed by the President of the Vancouver Police Union, regularly lobby MLAs in Victoria (BCPA, 2009; BCPA, 2010). The police go to great lengths to have their views enshrined in law and policy, influencing federal, provincial and local politicians at every opportunity.

In regard to police resistance to civilian investigation of police wrongdoing, the Ombudsman for Ontario, André Marin, has noted:

Police special interest groups, including powerful unions, have succeeded in keeping themselves immune from independent

oversight. The lessons learned from Taman, Harper and Dziekanski are ignored as police management and unions, normally at loggerheads, come together to fight the common enemy of effective civilian oversight, stampeding politicians in the process. The police lobby at times borders on the hysterical. It's all about the police maintaining control. Time after time, incident after incident, public outcry after public outcry, they wheel out the same tired old red herrings in an attempt to convince the public that the sky will fall if civilians are allowed to investigate police (Marin, 2009).

As noted above, in British Columbia, the new Premier did not make a public announcement regarding the creation of a civilian investigative agency in the province without first conferring with the head of the Vancouver Police Union. She also appears to have conferred closely with senior police management across the province prior to announcing the structure of the new legislation (DeRosa, 2011). Regarding rigorous oversight and civilian investigation of alleged police wrongdoing, police officers and management have been vocally opposed to genuine reform in the past. It appears that consulting with them prior to announcing reforms has had a positive effect in bringing them onside with significant developments like those arising in B.C..

### **Breathing New Life into the Death Determination Function**

In Canada, there are two different systems for investigating deaths, the coroner system and the medical examiner system. Provinces typically adhere to one model or the other. For example, B.C., Saskatchewan, Quebec, New Brunswick, the Yukon Territory, the Northwest Territories and Nunavut all use the coroner system, while the remaining jurisdictions use a medical examiner model. The trend in recent years has been to move away from a coroner system to a medical examiner model, a trend echoed south of the border (Hanzlick & Combs, 1998). Under the coroner model, death determination is made by a coroner who is usually a non-medical person – often a person with an investigative background (such as a former police officer). In the medical examiner system, the determination of the cause of death is made by a medically trained expert, typically a physician with expert training in pathology.

The purpose of an inquest is to ascertain the facts surrounding a death, including identifying the cause of death and the identity of the deceased. Additionally, one of the main purposes behind death inquests in either system is to identify how deaths can be prevented. Coroner's juries routinely identify various ways in which the death under investigation could



have been avoided. Accordingly, the inquest system provides one way through which preventive remedies can be identified.

At a recent forum on deaths in custody, Dr. John Butt, the former chief medical examiner for Alberta, and later for Nova Scotia, criticized the coroner system for a central flaw. That defect was the tendency of coroner systems to use former police officers in the role of coroner. It has been noted that “B.C.’s Coroners Act doesn’t require the chief coroner to have a medical background. For almost 30 years, between 1981 and 2010, the post was held by ex-police officers. Robert Galbraith was followed by Vincent Cain; Larry Campbell, who later became Vancouver mayor and is now a Liberal senator; and Terry Smith” (Pablo, 2010). The same reason that civilian investigators of police wrongdoing should not be former police officers applies to showing why the coroner system is less desirable than a medical examiner system. The public is not willing to trust former police officers running the inquiry into the circumstances of death involving serving police officers.

As noted above, British Columbia still retains the coroner system. Despite it being the less preferred system for conducting death investigations, prior to 2010, a coroner was required to conduct an inquest in regard to all deaths arising in police custody. However, in March of 2010, the B.C. government amended the Coroners Act taking away the mandatory inquest provision for deaths that arise in police custody under s. 18, replacing it with a discretionary power for the Chief Coroner to decline an inquest if he or she determines the death was natural and non-preventable, or there was no meaningful connection between the death and the nature of the care and supervision provided. An inquest may also be declined if there is going to be a public inquiry into the death. Given that so many of B.C.’s past Chief Coroners have been ex-police officers, it is disconcerting that a Chief Coroner is placed in the position to decline to carry out an inquest of a police-involved death. The main rationales behind holding an inquest are to determine whether a death was natural, to determine whether it was preventable, and to determine whether it arose as a result of the manner in which the detainee was treated. This legislative amendment is a cause of major concern in that it diminishes the role of the inquest as a layer of accountability regarding police-involved deaths by allowing a Chief Coroner to prejudge the outcome of an inquest.

Vancouver lawyer, Cameron Ward, has commented on the new provisions in the B.C. *Coroners Act*, noting:

A coroner’s inquest has often been the only avenue by which a deceased’s loved one can learn the truth about what happened... It

permits the full airing of the facts. In my view, this legislation reduces transparency, and it concerns me a great deal because it may result in these important cases being obscured and the details being withheld from public view (as quoted in Pablo, 2010).

The opportunity to identify new preventive strategies is greatly reduced by eliminating the need for mandatory inquests in all in-custody death cases.

### **Advisory Panel on Deaths in Custody**

In order to increase attention to the death in custody phenomenon and to provide alternatives to the present way of doing things, it is desirable that Canada develop an advisory panel on deaths in custody. The federal prison ombudsman has recently called for such a forum (Sapers, 2010); indeed, he has begun the ground work of bringing together a group of concerned professionals to deal with the matter. However, the initiative would have a greater likelihood of making positive contributions if it was supported by government resources. This would show both a genuine concern with the issue, as well as enable the panel to have a significant impact on policy development.

As Slarks and Wadham have shown in this volume, the United Kingdom employed a Forum on Preventing Deaths in Custody which was created in 2005. The Forum was an independent agency that sought to identify best practices to reduce deaths in prison and police custody. Following a governmental review, the Forum was replaced in 2009 by a three layered Ministerial Council on Deaths in Custody. That Council is composed of senior decision-makers, plus experts and practitioners in the field of in-custody deaths. A key component of the Council is the Independent Advisory Panel on Deaths in Custody. That panel, which came into being in early 2009, now provides advice to the Ministerial Board on Deaths in Custody which is headed by the Justice Minister.

Canada should develop a similar panel. While its mandate would undoubtedly look at policies and practices to minimize all in-custody deaths, an important aspect of the Board's work would be to tackle the issue of police-involved deaths. An advisory panel composed of experts and key stakeholders from across the country would develop increased awareness of the issues arising in the police-involved deaths context, and provide a venue for the discussion of preventive approaches.

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# POLICE-INVOLVED DEATHS

## The Need for Reform

Deaths as a result of police action or while in police custody happen with tragic frequency across Canada. Despite a remarkable number of deaths, Canada still has no comprehensive statistical collection or analysis of the circumstances of police-involved deaths. This collection of essays is an attempt to kick-start a more comprehensive discussion of the who, what, when, where and why of these deaths so that police, government and police accountability agencies, can work together to help prevent these deaths in the future.

Essays in this book examine police involved deaths from several perspectives: statistical, academic, legal and procedural. Authors include Canada's police accountability leaders, as well as the heads of international police accountability organizations who share their personal insights into this challenging and neglected area of law enforcement.

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