

THE FRANK PAUL INQUIRY

William H. Davies, Q.C. Commissioner
Appointed under the Public Inquiry Act, S.B.C. 2007, c. 9

FINAL SUBMISSIONS OF THE BC CIVIL LIBERTIES ASSOCIATION

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INTRODUCTION	2
PHASE I OF THE INQUIRY: THE CIRCUMSTANCES RELATING TO FRANK PAUL'S DEATH	3
Background	3
Frank Paul's first entry into jail and his release on December 5, 1998	3
Re-arrest and transport back to Vancouver Jail	3
Events at the jail.....	5
Events that occurred after the jail	7
PHASE II OF THE INQUIRY: THE INSTITUTIONAL RESPONSES TO FRANK PAUL'S DEATH	9
The Vancouver Police Department Homicide Investigation	9
The Criminal Justice Branch of the Ministry of the Attorney General.....	17
Vancouver Police Department Internal Investigation Section (IIS) Investigation ...	19
The Coroners Service.....	23
The Police Complaint Commissioner	25
CONCLUSION ON THE ADEQUACY OF THE RESPONSE TO THE DEATH OF FRANK PAUL	33
Vancouver Police Department	33
Recommendations for Change.....	34
Discrete Recommendations	35
Conclusion	37

INTRODUCTION

When this Inquiry convened, the BCCLA made opening remarks which included the following:

This Inquiry convenes on a sombre note of hope. There is hope this Commission can uncover the truth of what occurred on the night of Mr. Paul's death. There is hope that the Commission and its participants can identify systemic shortcomings in the Criminal Justice System that has failed aboriginal people. There is hope that the Commission, with the assistance of the participants here today, can propose concrete solutions.

With the submissions that follow, the BCCLA hopes that it can contribute to the concrete solutions which it hoped for when these proceedings commenced.

On behalf of the BCCLA, it must be said that this Commission of Inquiry represents a rare opportunity, by focusing a prism on the life and death of one of society's most disenfranchised, Mr. Frank Paul, to effect positive change for the unfortunately very many souls like him who continue to live among us. As a society, we must find a way to extend a far greater degree of dignity and humanity than that which was afforded to Frank Paul.

This Commission has had a unique and, perhaps, unprecedented opportunity to examine the response of various institutional agencies to disenfranchised people such as Frank Paul, both in life and death. This Commission of Inquiry now has a unique opportunity to effect positive change in the lives of many.

PHASE I OF THE INQUIRY: THE CIRCUMSTANCES RELATING TO FRANK PAUL'S DEATH

Background

1. Frank Paul was a Mi'kmaq from New Brunswick. In 1998, Frank Paul lived on the streets of Vancouver and did not have a residence. He was a chronic alcoholic, and suffered from a variety of severe medical conditions, including arthritis and seizures, and a recent head injury.
2. Frank Paul was removed from the Vancouver Police Department lockup at about 8:30 p.m. on December 5, 1998, and was left in a nearby alley by a police officer. His body was discovered in the alley early the next morning. A postmortem examination concluded he had died from hypothermia due to exposure and alcohol intoxication.
3. Frank Paul was regularly picked up by the police, ambulance and Saferide because he was intoxicated and unable to care for himself. Between April 24, 1998 and December 5th, 1998, Frank Paul was admitted to the sobering unit of the detox centre 48 times. He was also lodged at the Vancouver Police Department jail on numerous occasions.

Frank Paul's first entry into jail and his release on December 5, 1998

4. Around 11 a.m. on December 5, 1998, Frank Paul was arrested for being intoxicated in a state of intoxication in a public place. His arrest was designated as "Hold/State of Intoxication in a Public Place" (H/SIPP), designation used for arrests made under the provincial liquor legislation when the person was intoxicated and unable to care for himself.
5. Frank Paul was taken to the jail and held until about 5 p.m. until the jail sergeant was satisfied that Frank Paul would be able to care for himself. When he was released from the jail, he was able to stand, walk, and care for himself in a basic fashion.

Re-arrest and transport back to Vancouver Jail

6. Around 8 p.m., Constables Derek Peterson and Robert Turner, who at the time worked as patrol constables in the downtown eastside, found Frank Paul semi-unconscious laying on an empty wooden vegetable stand on Hastings Street, west

of Dunlevy Street. Frank Paul was protected from the elements by an awning that covered the vegetable stand.¹

7. It is beyond dispute that Frank Paul was intoxicated. Constable Peterson described Frank Paul's state that evening as "extremely intoxicated" and "passed out, semi-unconscious."²
8. Constable Peterson stated that Frank Paul "seemed to be unconscious when we arrived and then he was able to respond to Constable Turner while we were there."³ Frank Paul was unable to care for himself,⁴ so the officers arrested Frank Paul for being in a state of intoxication in a public place.⁵
9. At the behest of a Vancouver Police Department detective, Constable Peterson filled out a Miscellaneous and Supplementary Report (commonly known as a Form 19) on the morning of December 6, 2007, shortly after he left the scene of Frank Paul's death. The report corroborates the sworn testimony that Constable Peterson gave at the Inquiry concerning Frank Paul's intoxication: "Paul couldn't stand and was intoxicated and unable to care for himself..."⁶
10. Constables Peterson and Turner were experienced police officers. They testified that it was well known by the police that Frank Paul was an alcoholic and that he was frequently apprehended by the police for drinking in public places.⁷ Constables Peterson's and Turner's knowledge and previous experiences with Frank Paul left them well-equipped to assess Frank Paul's state of intoxication.
11. At the same time, and in the same area, Constables Peterson and Turner found Mr. Oscar Angel who was also extremely intoxicated. Constables Peterson and Turner called for a police wagon to transport Frank Paul and Mr. Angel.⁸
12. Constable Peterson determined that Mr. Angel should be sent to the sobering unit at the Vancouver detox centre, and assisted Mr. Angel into the police wagon when it arrived.⁹
13. Despite the fact that Frank Paul was completely incapacitated and exhibited no signs of violence, Constables Peterson and Turner inappropriately determined that Frank Paul was unsuitable for the detox centre because they believed he had a "propensity to lash out."¹⁰

¹ Peterson Transcript of Evidence, Nov. 27/07, p.130-131

² Peterson Transcript of Evidence, Nov. 27/07, p.138; Peterson Transcript of Evidence, Nov. 27/07, p.169

³ Peterson Transcript of Evidence, Nov. 27/07, p.168

⁴ Peterson Transcript of Evidence, Nov. 27/07, p.169

⁵ Peterson Transcript of Evidence, Nov. 27/07, p.145; Exhibit 40

⁶ Peterson Transcript of Evidence, Nov. 27/07, p. 158 –159; Exhibit 40

⁷ Peterson Transcript of Evidence, Nov. 27/07, p.129-30; Turner Transcript of Evidence, Nov. 26/07, p.142-143

⁸ Peterson Transcript of Evidence, Nov. 27/07, p.132

⁹ Peterson Transcript of Evidence, Nov. 27/07, p. 132, lines 8-10, p.133 line 1

¹⁰ Peterson Transcript of Evidence, Nov. 27/07, p. 135, lines 5-10

14. When pressed by Commission Counsel to recall any specific incidents in which Frank Paul was physically resistive or violent with police, Constable Peterson was unable to do so.¹¹ Constable Turner stated Frank Paul tended to be “belligerent with the police.” When asked by Commission Counsel to describe Frank Paul’s belligerent behaviour, Constable Turner stated: “He’d swear. He’d be difficult. He’d pull his arms, try not to be escorted anywhere.”¹²
15. According to Vancouver Police Department Materials, 1998 guidelines with respect to arrests for state of intoxication in a public place, officers were mandated to send people to detox, rather than jail. It appears that members of the Vancouver Police Department misconstrued what, if any, discretion they had with respect to transport to detox versus jail. Constable Turner agreed that Frank Paul was not even in any condition to be capable of being violent, yet he decided that Frank Paul was unsuitable for detox. He said he based that on common sense, resources, not taking unnecessary steps. He said he would never let detox staff exercise discretion as to who was suitable for detox, but rather would take that task upon himself.¹³
16. Frank Paul was so intoxicated that he was unable to walk. He had to be carried to the police wagon by three individuals: Constables Turner, Peterson and Instant.¹⁴

Events at the jail

17. It is beyond dispute that Frank Paul was in far worse condition when he returned to the jail than he had been when he left the jail earlier in the day. Frank Paul was soaking wet, unable to move his arms or legs, and barely coherent.
18. Constable Instant pulled Frank Paul out of the police wagon, and dragged him across the floor to the elevator. The jail video indicates that Frank Paul was so wet he left a visible wet streak on the concrete floor. Constable Instant hauled Frank Paul into the elevator, laying him across the floor of the elevator and took him to the fifth floor jail.
19. One of the jail staff alerted Sergeant Sanderson, who was in charge of the jail that night, that Frank Paul was in the elevator. Sergeant Sanderson assessed Frank Paul’s condition in the elevator. Constable Instant remained in the elevator. Jail guards Greg Firlotte and Michelle Renville were nearby. It appears based on a transcript of the jail audio recording that one of the jail guards informed Sergeant Sanderson that Frank Paul was totally incapable of walking.¹⁵ Frank Paul did not move his arms or legs, and was not capable of carrying on a conversation.

¹¹ Peterson Transcript of Evidence, Nov. 27/07, p. 135 - 136

¹² Turner Transcript of Evidence, Nov. 26/07, p.162

¹³ Turner Transcript of Evidence, Nov. 27/07, p.55-61; Exhibit 37

¹⁴ Peterson Transcript of Evidence, Nov. 27/07, p. 134, p. 140; Exhibit 40

¹⁵ Exhibit 188

20. Sergeant Sanderson testified that he determined that he did not believe that Frank Paul was intoxicated. Sergeant Sanderson stated that he based his belief that Frank Paul was not intoxicated on his assumption that “it would have been extremely difficult for Frank Paul to have left the jail in a period of around two hours to go somewhere and to obtain enough alcohol to become intoxicated again.”¹⁶
21. Sergeant Sanderson’s assertion that it would be “extremely difficult” for Frank Paul to have become intoxicated was profoundly wrongheaded and defies commonsense. There were a number of liquor stores within a few blocks of the Main Street jail. The Commission heard medical testimony that an individual could become grossly intoxicated within two hours. “Rice wine,” a potent, non-potable cooking liquor with a high alcohol content was widely available at the time, and could be purchased for just a few dollars. Frank Paul was known to consume the product.
22. Either Sergeant Sanderson was not truthful when he testified that he did not believe Frank Paul was intoxicated or he committed a profoundly disturbing error in judgment. Sergeant Sanderson’s experience as a jail sergeant and his routine contact with the chronic alcoholics that were taken to the jail to sober up, should have left him well equipped to recognize the symptoms of acute intoxication.
23. Sergeant Sanderson testified that because Frank Paul was not intoxicated at the time of his arrest, he believed that Frank Paul had been arrested in error, and the arrest was unlawful. Sergeant Sanderson did not request that a nurse examine Paul, despite the fact that there was a nurse on call that night in the jail.
24. Sergeant Sanderson ordered Constable Instant to “breach” Frank Paul. Sergeant Sanderson was not authorized to order such an action. Sergeant Sanderson testified that he did not order a breach, but the testimony of Constable Instant and Constable Instant’s duty report, which report that Sergeant Sanderson did order such an action, and the radio dispatch transcriptions and the transcript of the jail audio should be preferred over Sergeant Sanderson’s self-serving denial.
25. Sergeant Sanderson ordered Constable Instant to take Frank Paul to Broadway and Maple. He did not tell Constable Instant what to do with Frank Paul once he brought him there and he did not give him precise instructions on where to leave him. Sergeant Sanderson was unable to give Constable Instant an address to take Frank Paul to because Frank Paul was homeless.
26. Sergeant Sanderson knew that Frank Paul was homeless. Sergeant Sanderson denied throughout his testimony that he knew Frank Paul lived on the streets. He claimed in his testimony and in his duty report that he thought Frank Paul would be able to “bunk down” with his friends in the Maple and Broadway area and get out of the cold and wet weather. Either Sergeant Sanderson actually believed that

¹⁶ Sanderson Transcript of Evidence, Jan. 7/08 p.55

Frank Paul would be able to secure some sort of shelter, in which case he was acutely naïve or he was not truthful when he testified to this Commission.

27. Mr. Greg Firlotte helped Constable Instant drag Frank Paul back into the wagon. Mr. Firlotte naively believed that Frank Paul was going to be driven home. Although Mr. Firlotte wrote in his duty report that Frank Paul appeared “alert and coherent and not under the influence of alcohol” when he was dragged to the wagon, Mr. Firlotte admitted on the stand that he now realized that Frank Paul was in fact drunk.¹⁷
28. Frank Paul was soaking wet when he was loaded back into the wagon.¹⁸ It was raining on and off that day, and the temperature was just a few degrees above freezing.

Events that occurred after the jail

29. Constable Instant was dispatched to the Cobalt Hotel in the 900 block of Main Street to take three individuals into custody. Constable Instant still had custody of Mr. Angel, and moved him from the rear compartment to the side compartment, where he joined Frank Paul.
30. While at the Cobalt Hotel, Constable Instant had a brief conversation with Constable James English. Constable Instant testified that Constable English advised him that Frank Paul was homeless and did not reside at Maple and Broadway, and that Constable English suggested that Constable Instant should leave him in the rear lane behind the detox centre. Constable Instant’s recall of the conversation was memorialized in his duty report.
31. Constable English testified that Constable Instant sought his advice and he assisted Constable Instant by outlining a number of possible courses of action. Those courses of action included, but were not limited to, seeking further instructions from Sergeant Sanderson, seeking to have Frank Paul admitted at the detox centre, and obtaining advice from a more senior ranking officer. Constable English did not make any contemporaneous notes of this purported exchange, and did not document it in his duty report. The testimony of Constable Instant should be preferred on this point. Because Constable Instant acted on Constable English’s defective suggestion, Constable English was complicit in Frank Paul’s untimely death.
32. Shortly before 9 p.m., Constable Instant arrived at the detox centre. John Collens, a Detox Centre employee, walked to the side of the wagon to help assist Mr. Angel out of the wagon and into the facility.

¹⁷ Firlotte Transcript of Evidence, Nov. 28/07, p.169

¹⁸ Firlotte Transcript of Evidence, Nov. 28/07, p.169

33. Mr. Collens testified that he said “hello” to Frank Paul and that Frank Paul was unresponsive. He testified that Frank Paul looked at him, which is the most compelling evidence on point that Frank Paul did not die in the wagon.
34. Mr. Collens provided a statement to Vancouver Police Department on December 12, 1998, in which he stated that one of his colleagues informed Constable Instant of a new shelter “Haven House” where Constable Instant might be able to take Frank Paul. Constable Instant testified that he had no recollection of the exchange. Mr. Collens later asked his colleagues if they recalled the suggestion, and no one he spoke to remembered having that exchange. The evidence on this point is inconclusive.
35. After leaving Detox, Constable Instant drove down the alley of the 300 block of East 2nd Avenue. In his duty report, he stated that: “the alley I was in seemed well illuminated and sheltered on three sides.” He decided to leave Frank Paul there.
36. In fact, the location where Constable Instant left Frank Paul offered no shelter. On cross examination, Constable Instant attempted to amend the statement in his duty report by stating that the three-sided shelter he was referring to was a shrub that Frank Paul could have crawled underneath to escape the elements.
37. Despite the absurdity of this contention, and despite the fact that photographs from the scene of Frank Paul’s death clearly indicate that the lane is an open area devoid of shelter, Constable Instant’s statement was uncritically accepted by the Vancouver Police Department and the BC Coroners Service in their subsequent investigations.
38. Constable Instant wrote in his duty report that “Frank Paul attempted to slide out of the wagon and I assisted him with existing from the side compartment. I walked him to the north side of the alley and leaned him up against the wall beside s large shrubbery. His legs were outstretched and I returned to the wagon and retrieved his shoe and came back and placed it on his stockinged foot.”
39. Constable Instant’s report of how he left Frank Paul in the alley is highly suspect. In the jail, shortly before Constable Instant deposited him in the alley, Frank Paul was unable to walk or move his arms and legs and had to be dragged by two officers to the wagon. Frank Paul’s body was found supine in the alley, meters away from the wall of the building. His clothing was in disarray; his jacket and another article of clothing were underneath his body. His pants were below his hips, exposing his groin and buttocks, and his shirts were drawn up towards his chest, exposing his stomach. There were scrapes and marks and his body that could be consistent with dragging against across the gravel. His shoes were not on his feet.
40. The position of Frank Paul’s body and his clothing justifies the inference that Frank Paul was left in the alley in same way as when he was found dead. Constable Instant’s testimony on how he left Frank Paul, and Frank Paul’s ability

to walk, is highly suspect. Unfortunately, due to the Vancouver Police Department's inadequate homicide investigation, including its failure to document and collect evidence at the scene of Frank Paul's death, we are unable to draw a definitive conclusion about whether Constable Instant was telling the truth in his duty report and when he testified on the stand.

PHASE II OF THE INQUIRY: THE INSTITUTIONAL RESPONSES TO FRANK PAUL'S DEATH

The Vancouver Police Department Homicide Investigation

i) Vancouver Police Department practices concerning the investigation of in-custody deaths

41. The Vancouver Police Department conducted the criminal investigation into the death of Frank Paul. The investigation was conducted by the Homicide Squad of the Vancouver Police Department Major Crime Section. The investigation occurred between December 1998 to May 1999.
42. From the first moment it was assigned to investigate Frank Paul's death, the Homicide Squad was responsible for making sure that all relevant evidence was gathered during the first crucial hours after Frank Paul's death and in the proceeding days of the investigation. It was charged with identifying and pursuing all potentially relevant facts and issues. Every other investigation arising out of Frank Paul's death would rely to some degree or another on the Homicide Squad's, and by extension, the Vancouver Police Department's, professionalism, independence, objectivity, and commitment to thoroughness.
43. From the outset of its inquiry into the death of Frank Paul that began in the early morning hours of December 6, 1998, the Homicide Squad conducted a woefully defective investigation. The investigation resulted in a final investigative report that was full of omissions, oversights, and avenues left unpursued. The report left many critical questions unanswered.
44. The report was relied upon by every subsequent investigative body: the Criminal Justice Branch, the Coroner's Service, the Vancouver Police Department Internal Investigation Section, and the Police Complaint Commissioner. The failings of the report polluted each subsequent investigation and review.¹⁹
45. The Commission heard extensive testimony from Detective Staunton and Inspector Porteous about the manner in which the Vancouver Police Department investigates the deaths of individuals who die while they are under the care and custody of the police. The practice of the Major Crimes Section was to assign the Homicide Squad, a subsection of the Major Crimes Section, to investigate every

¹⁹ We are unable to assess whether the Vancouver Police Department investigation affected the decisions made by the Criminal Justice Branch, because those activities have been shielded from review at this Inquiry.

in-custody death.²⁰ The investigations of in-custody deaths culminated in a Sudden Death Report that contained a summary of the statements and evidence gathered. In cases of in-custody deaths, where the individual potentially died as a result of police conduct, the practice was to prepare a report that did not make judgments about the credibility of witnesses or the veracity of statements, and did not highlight or identify outstanding issues or unanswered questions, or inconsistencies in the evidence.²¹ In all investigations into in-custody deaths, the Sudden Death Report must be forwarded to Crown Counsel.

46. A Sudden Death Report prepared in the case of an in-custody death has been referred to as a “neutral” report because it does not make any recommendation to Crown Counsel as to whether the police officer or officers involved in the individual’s death should be criminally charged.²² Unlike a typical report to Crown Counsel that would include a section analyzing whether a certain charge, such as criminal negligence causing death, would be warranted and whether the elements of the offense were made out by the evidence, a neutral report makes no such recommendation.²³
47. Today, in-custody deaths are investigated in the same manner - a neutral report is sent to Crown Counsel that does not recommend charges and does not analyze or identify inconsistencies in the evidence. The Vancouver Police Department had not admitted to any weaknesses inherent in the present system, and has not tabled any proposed changes to the manner in which in-custody deaths are investigated.

ii) Investigation at the scene of Frank Paul’s death

48. Frank Paul was found dead in the early morning hours of December 6, 1998 in the 300 block of East 1st by Colin Robertson, a man who was attending a party in the neighbourhood and was searching outside for a resident’s lost cat.²⁴ After Mr. Robertson called 911, the dispatcher radioed Constables Peterson and Turner to the scene. They were the first officers on the scene.²⁵ They arrived at around 2:50 am.²⁶
49. Two ambulances also attended the scene. One was an Advanced Life Support car, equipped with life-support technology. On orders from a doctor, efforts to resuscitate Frank Paul were discontinued.²⁷
50. Acting Sergeant Winters arrived at the scene half a minute after Constables Peterson and Turner.²⁸ Several minutes later, Constable Instant was alerted that

²⁰ Porteous Transcript of Evidence, Feb. 21/08, p.3

²¹ Staunton Transcript of Evidence, Feb. 14/08, p.15

²² Staunton Transcript of Evidence, Feb. 14/08, p.104

²³ Staunton Transcript of Evidence, Feb. 14/08, p.105-107

²⁴ Peterson Transcript of Evidence, Nov. 27/07, p.164-5

²⁵ Peterson Transcript of Evidence, Nov. 27/07, p.145

²⁶ Turner Transcript of Evidence, Nov. 27/07, p.41; Exhibit 35

²⁷ Memorandum to Participants of Non-controversial Facts from Brock Martland, Associate Commission Counsel

there was a sudden death at the alley where he left Frank Paul.²⁹ Constable Instant arrived at the scene several minutes after Constables Peterson and Turner.³⁰ Constable Instant told Acting Sergeant Winters that he had left Frank Paul at the location.

51. The inspector in charge of the city for the night, known as Car 10, arrived at the scene sometime after 3:30 a.m.³¹ The officer assigned to Car 10 that night was inspector Davies.
52. The supervisory sergeant and forensics members arrived at the scene and secured the area. They took photographs of the state of Frank Paul's clothing and his body.³² Constable Callard was in charge of collecting forensic information, taking photographs and checking to see if there were outward signs of a reason for the death of Frank Paul such as obvious signs of trauma.³³
53. Detective Staunton, since retired, was the on call officer for the Major Crimes Section and was dispatched to investigate Frank Paul's death. Detective Staunton and Sergeant Boyd arrived together at the scene around 4:50, after the forensics members and Acting Sergeant Winters.³⁴
54. Detective Staunton was responsible for directing the investigation at the scene. From the outset, Detective Staunton did not approach the scene as a suspicious death, and failed to collect and direct others to collect pertinent information.
55. Detective Staunton was immediately confronted with inconsistencies in the evidence that he failed to identify. His failure resulted in the permanent loss of critical evidence and a compromised investigation.
56. Detective Staunton was briefed at the scene that Constable Instant reported that he had left Frank Paul against the wall of the building in the alley.³⁵ Detective Staunton admitted that from the outset of his investigation it was clear to Detective Staunton that Constable Instant was under suspicion, or at least it had to be investigated whether Constable Instant had contributed to Frank Paul's death.³⁶ Detective Staunton found Frank Paul lying in a supine position, several meters from the wall where Constable Instant said he left him.³⁷ Detective Staunton

²⁸ Turner Transcript of Evidence, Nov. 27/07, p.41; Exhibit 35

²⁹ There is some inconsistency in the evidence as to whether Constable Instant was initially alerted of Frank Paul's death by Constables Peterson and Turner or whether Constable Instant learned of the death after he ran a routine unit status before he went on his break. For example, compare Turner Transcript of Evidence, Nov. 27/07, p.41 with Instant Transcript of Evidence, Jan. 11/08, p.31.

³⁰ Turner Transcript of Evidence, Nov. 27/07, p.41; Exhibit 35

³¹ Turner Transcript of Evidence, Nov. 27/07, p. 42; Exhibit 35

³² Staunton Transcript of Evidence, Feb. 14/08, p. 24

³³ Staunton Transcript of Evidence, Feb. 14/08, p.22

³⁴ Staunton Transcript of Evidence, Feb. 14/08, p.28

³⁵ Staunton Transcript of Evidence, Feb. 14/08, p.23

³⁶ Staunton Transcript of Evidence, Feb. 14/08, p.32-33

³⁷ Staunton Transcript of Evidence, Feb. 14/08, p.23; Exhibit 17

never questioned the veracity of Constable Instant's report that he left Frank Paul against the wall.³⁸

57. Detective Staunton did not direct the forensics team to take photographs or conduct investigations to see if there was physical evidence which corroborated Constable Instant's account of where he left Frank Paul.³⁹ The forensics team did not take any pictures of the bush or the wall where Constable Instant stated he left Frank Paul, and Detective Staunton did not direct the team to do so.⁴⁰
58. Frank Paul's body was found partially unclothed and was laying on top of a red jacket and another piece of clothing. His pants were partially pulled down and his groin was exposed. His shoes were found approximately six feet from his body.⁴¹ Detective Staunton testified that he did not attach any significance to Frank Paul's state of undress.⁴² Rather than questioning the veracity of Constable Instant's account of events, Detective Staunton assumed, without any factual basis grounded in the physical evidence, that Frank Paul must have unclothed himself and crawled to the location where he died.⁴³
59. Detective Staunton did not question whether Frank Paul was alive at the time that Constable Instant left him in the alley. He testified that "I have no reason to believe that Constable Instant would lie about releasing the individual and him not being alive at that time."⁴⁴
60. Sergeant Boyd went to the detox centre to interview John Collens, the detox staff member who admitted Oscar Angel to detox while Detective Staunton was still at the scene.⁴⁵ Neither Sergeant Boyd nor Detective Staunton made any attempt in the course of the investigation to locate or interview Oscar Angel or any of the other witnesses in the wagon. Commission Counsel endeavoured to locate these witnesses for the purpose of gaining their attendance at the Frank Paul Inquiry, but they were unable to find them. Detective Staunton's oversight in this regard resulted in the permanent loss of evidence.
61. Detective Staunton did not order a canvass of the area for witnesses, stating that it was not a consideration at the time.⁴⁶ Rather than interviewing potential witnesses individually, he asked witnesses to question other people as to whether they had any relevant information. On one occasion, Mr. Staunton asked people at a neighbourhood party to canvass other party guests as to whether they had seen

³⁸ Staunton Transcript of Evidence, Feb. 14/08, p.25

³⁹ Staunton Transcript of Evidence, Feb. 14/08, p.25

⁴⁰ Staunton Transcript of Evidence, Feb. 14/08, p.25-26; Exhibit 17

⁴¹ Exhibit 17

⁴² Staunton Transcript of Evidence, Feb. 14/08, p.26

⁴³ Staunton Transcript of Evidence, Feb. 14/08, p.26-27

⁴⁴ Staunton Transcript of Evidence, Feb. 14/08, p.29

⁴⁵ Exhibit 91, p.54.

⁴⁶ Staunton Transcript of Evidence, Feb. 14/08, p.31

anything. On another occasion, he asked Mr. Collens to ask his colleagues if they shared Collens' memory of the incident.⁴⁷

62. Constable Instant testified that after he arrived at the scene he examined the location of Frank Paul's body.⁴⁸ Detective Staunton did not monitor Constable Instant's activities at the scene of the death, and testified that he did not remember Constable Instant looking at Frank Paul's body.⁴⁹ Detective Staunton testified that in general an officer under suspicion should not be permitted to be present at the scene of the death, but stated that Constable Instant arrived at the scene before he did and his activities were out of his control.⁵⁰ Nonetheless, Detective Staunton did not take any steps after he arrived to limit or direct Constable Instant's activities at the scene.
63. Detective Staunton did not attempt to segregate any of the police witnesses at the scene who had had contact with Frank Paul shortly before his death in order to ensure that their recall of events would not be contaminated or compromised.
64. Detective Staunton's failure to segregate witnesses may have contaminated the recall of Constables Peterson and Turner as to where they found Frank Paul's dead body. Constable Peterson testified that he found Frank Paul in a slouched but seated position at the scene.⁵¹ Constable Turner also stated that he found Frank Paul in a seated position against the wall.⁵²
65. Under cross examination, Constable Peterson stated that Frank Paul's body must have been moved from the wall some time after he and Constable Turner arrived at the scene; yet this account contradicts the evidence of Colin Robertson, the first witness at the scene, the evidence of the EHS attendant, the affidavit evidence of Sergeant Boyd, and the photographs that were taken at the scene. Given that neither Constable Turner's nor Constable Peterson's Miscellaneous and Supplementary Reports (commonly known as a Form 19) state the position that they found Frank Paul's body at the scene, the other evidence on this point should be taken as conclusive and it should be determined that the memories of Constables Peterson and Turner on this point are unreliable. The likely explanation for the constables' mistaken memories is that they spoke to Constable Instant about his version of the events and learned that he reported that he left Frank Paul against the wall, inadvertently substituting his version of events with their own recall of the scene. Constable Peterson admitted that he spoke with Instant some time after the incident.⁵³

⁴⁷ Staunton Transcript of Evidence, Feb. 14/08, p.142-143

⁴⁸ Instant Transcript of Evidence, Jan. 11/08, p.37

⁴⁹ Staunton Transcript of Evidence, Feb. 14/08, p.31

⁵⁰ Staunton Transcript of Evidence, Feb. 14/08, p.32

⁵¹ Peterson Transcript of Evidence, Nov. 27/07, p.145

⁵² Turner Transcript of Evidence, Nov. 26/07, p.172

⁵³ Peterson Transcript of Evidence, Nov. 27/07, p. 148

66. Despite the fact that Constable Instant was under a cloud of suspicion, Detective Staunton did not ask Constable Instant to submit to questioning. Detective Staunton did not ask Sergeant Sanderson to submit to questioning. In fact, not one of the responding or witness officers, including Corrections Officer Firlotte, Constable Peterson, or Constable Turner was ever interviewed or asked to submit to an interview.
67. Some of the officers were immediately provided with legal counsel. Constables Peterson, Turner, and Instant and Sergeant Winters spoke with legal counsel, Tom Doust, on Sunday, December 6, before the end of their shifts. Mr. Doust reviewed the Miscellaneous and Supplementary reports before they were submitted to Detective Staunton.⁵⁴
68. Detective Staunton testified that it was the accepted practice to provide a responding officer, such as Constable Instant, who was associated with an in-custody death, with an opportunity to speak to legal counsel before being questioned or ordered to provide a duty report.⁵⁵
69. Detective Staunton testified that it would be an extraordinary step for a detective to take a warned statement of an officer in an in-custody death investigation, and that such a step would not be taken unless there was clear evidence of a crime having taken place.⁵⁶ He further testified that an officer under suspicion in an in-custody death was never requested to give a warned statement during his tenure with the homicide squad.

iii) Investigation into why Frank Paul was refused care at the jail the evening of December 5, 2007

70. One of the key questions of the investigation was why Frank Paul was refused care at the jail the evening of December 5, 2007. In order to find an answer to that question, Detective Staunton obtained statements from Sergeant Sanderson and from a number of people in and around the jail.
71. Sergeant Sanderson was never ordered to provide a duty report, however he did provide a statement.⁵⁷ The statement was the only information that Detective Staunton ever received from Sergeant Sanderson.⁵⁸ Detective Staunton was satisfied that the statement was complete and trustworthy, so he did not request further information from Sergeant Sanderson.⁵⁹ Detective Staunton understood from the statement that Sergeant Sanderson's justification for not lodging Frank Paul at the jail was that Frank Paul was not intoxicated.⁶⁰

⁵⁴ Turner Transcript of Evidence, Nov. 27/07, p.50-51

⁵⁵ Staunton Transcript of Evidence, Feb. 14/08, p.56-57

⁵⁶ Staunton Transcript of Evidence, Feb. 14/08, p.73

⁵⁷ Staunton Transcript of Evidence, Feb. 14/08, p.38

⁵⁸ Staunton Transcript of Evidence, Feb. 14/08, p.39

⁵⁹ Staunton Transcript of Evidence, Feb. 14/08, p.39-40

⁶⁰ Staunton Transcript of Evidence, Feb. 14/08, p.40

72. When Sergeant Sanderson's statement was contradicted by the evidence of the autopsy report, which showed that Frank Paul had a high level of intoxication, Detective Staunton did not seek to question Sergeant Sanderson; he did not order a duty report from Sergeant Sanderson; and he made no other attempts to test Sergeant Sanderson's statement.⁶¹ In fact, Detective Staunton believed that Sergeant Sanderson's assessment of Frank Paul's level of intoxication was likely incorrect, yet he never expressed his opinion in the report.⁶²
73. Detective Staunton admitted that the video and photo stills were, at the very least, inconsistent with Sergeant Sanderson's statement.⁶³
74. Sergeant Sanderson's statement omitted to say whether Frank Paul smelled of alcohol. Constable Turner stated in his duty report that Frank Paul's speech was slurred, he was incoherent and smelled of rice wine. Detective Staunton testified that he did not recall whether he identified the inconsistency in the observation of the arresting officer and the jail NCO.⁶⁴
75. Sergeant Sanderson's statement did not state that Frank Paul was unable to stand or crawl when he was brought to the jail the second time on December 5. The omission in the report was highlighted by the video and photo stills of Frank Paul being dragged into and out of the jail, yet once again, Detective Staunton failed to probe the omission.
76. Detective Staunton was aware that Frank Paul was homeless.⁶⁵
77. Detective Staunton testified that it was not his responsibility to assess or reconcile these questions.

iv) Investigation into why Frank Paul was released by Constable Instant into the alley and whether Frank Paul could care for himself at the time of release

78. Constable Instant stated in his Miscellaneous and Supplementary Report that he spoke with Constable English at the Cobalt Hotel. He stated that Constable English advised him that Frank Paul was homeless, and that a safe place to release him would be in the lane behind the detox.⁶⁶ Detective Staunton did not seek to obtain a statement from Constable English until after he submitted his report to Crown Counsel. Crown counsel requested that he do so.
79. Although Constable Instant said in his Duty Report that the place where he left Frank Paul was sheltered on three sides, the physical evidence shows that such was not the case. Detective Staunton never came to grips with that inconsistency, and he explained that as "oversight".

⁶¹ Staunton Transcript of Evidence, Feb. 14/08, p.40

⁶² Staunton Transcript of Evidence, Feb. 14/08, p.88

⁶³ Staunton Transcript of Evidence, Feb. 14/08, p.49-50

⁶⁴ Staunton Transcript of Evidence, Feb. 14/08, p.51

⁶⁵ Staunton Transcript of Evidence, Feb. 14/08, p.52

⁶⁶ Instant Transcript of Evidence, Jan. 11/08, p.12-13

80. The essential question in respect to Constable Instant was whether Frank Paul was capable of caring for himself at the time Constable Instant left him in the alley. During the course of the investigation, Detective Staunton determined that Frank Paul's ability to care for himself was very much in doubt, yet in keeping with the practice of investigating in-custody deaths, Detective Staunton did not comment on the question in his report to Crown Counsel.⁶⁷
81. There was substantial evidence that suggested that Frank Paul would have been incapable of caring for himself - most notably the jail video that showed Frank Paul being dragged and carried into a police wagon less than an hour before Constable Instant left him in the alley. There was substantial evidence to doubt the veracity of Constable Instant's duty report, yet no attempt was made to interview Constable Instant to question him about this issue. In fact, Detective Staunton testified that there was never any issue in his mind that Constable Instant was telling the truth.⁶⁸
82. Despite the fact that there was substantial evidence which indicated that Frank Paul could not walk, and was incapable of most if not all movement, Detective Staunton did not question whether Constable Instant's statement in his duty report that he walked Frank Paul to the wall of the building in the alley was credible.⁶⁹
83. Similarly, Detective Staunton did not question whether the statement that Greg Firlotte provided that stated that Frank Paul was alert, coherent, and not under the influence of alcohol was credible.⁷⁰
84. Detective Staunton testified that he did not identify the inconsistencies in the evidence until he was questioned by Commission Counsel.⁷¹ The staff sergeant and the inspector reviewed and approved Detective Staunton's investigation report after it was completed - there was no request for additional investigation.
85. During the course of his investigation, Detective Staunton communicated with Constable Instant about the progress of the investigation. On December 7, 1998 Constable Instant met with his lawyer, Mr. Doust, at the lawyer's office receiving advice and preparing his duty report.⁷² He dropped it off for Detective Staunton at 5:30 pm on December 7. On December 8, Constable Instant called Detective Staunton and inquired about the investigation. Constable Instant took notes of the conversation and testified that he asked Detective Staunton a series of questions.⁷³ He testified that Detective Staunton told him that the autopsy had been completed, that the factors of death were unknown, that there were no signs of trauma, and

⁶⁷ Staunton Transcript of Evidence, Feb. 14/08, p.68

⁶⁸ Staunton Transcript of Evidence, Feb. 14/08, p. 71

⁶⁹ Staunton Transcript of Evidence, Feb. 14/08, p.71

⁷⁰ Staunton Transcript of Evidence, Feb. 14/08, p.72

⁷¹ Staunton Transcript of Evidence, Feb. 14/08, p.73

⁷² Staunton Transcript of Evidence, Feb. 14/08, p.116

⁷³ Instant Transcript of Evidence, Jan. 11/08, p.51

that Frank Paul was well dressed with a jacket, fleece and several shirts.⁷⁴ Detective Staunton testified that in a normal investigation, that is, an investigation that was not an in-custody investigation, he would not provide details of that nature to someone who was a potential suspect in a serious crime.⁷⁵

86. Despite being relatively new to the position, and despite the sensitive nature of the investigation, Detective Staunton did not receive any advice or instruction from his supervisors concerning the Frank Paul investigation. At the completion of the Sudden Death Report, it was reviewed and approved as being complete by Sergeant Boyd.

v) *Vancouver Police Department Public Forum*

87. Even at the time of the public forum in April 2007, the Vancouver Police Department continued to disseminate erroneous information with respect to the events leading up to the death of Frank Paul. By way of example only, they perpetuated the notion that Sergeant Sanderson believed that Mr. Paul “could not be intoxicated”, apparently because of the short time between his release from jail and subsequent attendance thereat. Having never interviewed Sergeant Sanderson, the Vancouver Police Department put forward his opinion that Mr. Paul’s condition was no worse than his normal state of post jail-stay sobriety.
88. The public forum included a PowerPoint presentation which depicted photographs of various things, including a photograph purporting to show the place where Constable Instant deposited the body of Frank Paul, which was nowhere close to accurate. The photograph showed a location immediately outside detox, in what was the equivalent of their loading bay. As this Commission well knows, the actual location was approximately one block to the west in a place which was entirely uncovered.
89. The public forum stated emphatically that the wagon driver had left Mr. Paul “in the laneway, against a building and under cover”. By that time, it would have been patently obvious to the Vancouver Police Department that the location in which the wagon driver left Mr. Paul could not in any way be said to be “under cover”. In short, the Vancouver Police Department, as a corpus, continued at least until the spring of 2007 to misrepresent some of the salient facts surrounding Mr. Paul’s death.

The Criminal Justice Branch of the Ministry of the Attorney General

90. Detective Staunton referred the Sudden Death Report to Crown counsel to consider whether the facts justified the laying of a criminal charge. The Crown advised the Vancouver Police Department of its decision not to proceed with criminal charges in December 1999.

⁷⁴ Staunton Transcript of Evidence, Feb. 14/08, p.117-118

⁷⁵ Staunton Transcript of Evidence, Feb. 14/08, p.118

91. The Criminal Justice Branch of the provincial Ministry of the Attorney General made four other assessments on various occasions as to whether there was sufficient evidence to proceed with the charges against any officers relating to the death of Frank Paul. In all the assessments, the Criminal Justice Branch determined that there was insufficient evidence to meet the criminal standard of proof beyond a reasonable doubt.
92. During the course of this Inquiry, the Criminal Justice Branch brought an application submitting that the scope of the Inquiry's jurisdiction was extremely limited. The Criminal Justice Branch submitted that no individual prosecutor and no representative of the Criminal Justice Branch involved in the Frank Paul case could be subjected to questioning about his or her exercise of discretion in the Frank Paul case. The Criminal Justice Branch did not make any witness available to the Commission, and no evidence of the Criminal Justice Branch was heard.
93. Commissioner Davies ruled on February, 27, 2008 that this Inquiry is authorized to inquire into the Criminal Justice Branch's exercise of prosecutorial discretion in the Frank Paul case. The Criminal Justice Branch has sought judicial review of the Commissioner's ruling.
94. Undoubtedly recognizing that there was legitimate public concern respecting the Criminal Justice Branch's response to the death of Frank Paul, the Ministry of the Attorney General unambiguously mandated this Inquiry, by the terms of reference, to make findings of fact regarding circumstances relating to Frank Paul's death, including findings of fact respecting the response of the Criminal Justice Branch to the death of Frank Paul.
95. In the course of the Inquiry, the Commission has heard evidence that in British Columbia a police officer has never been convicted of a crime where an individual died in police custody. The Vancouver Police Department presented evidence of just one instance where the Criminal Justice Branch determined that there was sufficient evidence to proceed with the charges against an officer where an individual allegedly died as a result of police conduct. The charge did not result in a conviction. We cannot be certain that we have all the evidence on point. Nonetheless, this apparent paucity of charges laid against police officers is disquieting given the fact that since 1992, 267 people have died while in the custody of or while being pursued by the police in British Columbia, an average of almost 18 each year.
96. The BCCLA does not express any opinion about the charging decisions that were made and the reasons for doing so in the case of Frank Paul because the BCCLA has not heard the testimony of individual prosecutors and representatives of the Criminal Justice Branch involved in the Frank Paul case. The individuals who made the charge assessment decisions in the Frank Paul case should have fulfilled their duty to testify as to what they did, what materials they reviewed, what decisions they made and the reasons for those decisions so that Frank Paul's family and the public could arrive at a fair conclusion about their conduct.

97. The Ministry of the Attorney General established the broad terms of reference for this Inquiry; it included the Criminal Justice Branch among the public bodies whose conduct would be reviewed. It is disappointing at best and dishonourable at worst that the Ministry of the Attorney General now seeks to narrow the scope of this Inquiry and shield the activities of the Criminal Justice Branch from public review.
98. The BCCLA concurs with the result of Commissioner Davies' ruling, and agrees with his assessment that:

“[T]here is public concern respecting the Branch's response, and this concern relates to both the processes followed and the decisions made. That being so, the Branch is currently under a cloud for its response to Frank Paul's death. It is too early to tell whether or not that cloud is warranted. Only a full and public examination of the Branch's charge assessment will resolve that issue.”

Vancouver Police Department Internal Investigation Section (IIS) Investigation

i) The Vancouver Police Department Police Act Investigation

99. Following the completion of the criminal investigation, the Frank Paul file was assigned to a Vancouver Police Department Internal Investigator on May 20, 1999.
100. After reviewing the file, Sergeant Hobbs laid a complaint under s.52 of the *Police Act* against Sergeant Sanderson and Constable Instant.
101. Sergeant Boutin assumed conduct of the file from Sergeant Hobbs in September of 1999.⁷⁶ Sergeant Boutin had conduct of the Frank Paul case up to the imposition of disciplinary sanctions against the two officers.⁷⁷
102. Sergeant Boutin was forwarded a copy of the criminal investigation file. The internal investigation relied almost exclusively on the criminal investigation.⁷⁸ Sergeant Boutin did not take any steps to investigate the matter independent of Detective Staunton.⁷⁹
103. Now retired police Sergeant Boutin testified that the general practice of IIS is to rely on the Major Crimes investigation report. Typically, IIS did not undertake its own investigation of the facts.⁸⁰

⁷⁶ Boutin Transcript of Evidence, Feb. 11/08, p. 24

⁷⁷ Boutin Transcript of Evidence, Feb. 11/08. p. 11

⁷⁸ Boutin Transcript of Evidence, Feb. 11/08. p. 11

⁷⁹ Boutin Transcript of Evidence, Feb. 11/08. p. 12

⁸⁰ Boutin Transcript of Evidence, Feb. 11/08. p. 10

104. In the course of the *Police Act* investigation, the Vancouver Police Department requested an extension of time for the investigation to be completed. The Police Complaint Commissioner granted a three-month extension of time to April 2, 2000.
105. In assessing whether or not a *Police Act* default had been committed, Sergeant Boutin was improperly influenced by the Crown's decision not to lay criminal charges. Sergeant Boutin testified: "If it had been a negligent thing to do, the Crown in reviewing this file prior to my conducting this or writing this report would have charged these officers with criminal negligence, and they didn't."⁸¹
106. Sergeant Boutin concluded in his discipline report that one of the mitigating factors in meting out discipline to the officers was the fact that "the deceased's lifestyle of chronic alcoholism, coupled with no fixed address status, when taken together with his weakened physical state, made the manner of his death a highly probable event, even in the absence of police contact." By stating that Frank Paul's homelessness, alcoholism and medical condition were counterbalancing factors to be considered, Sergeant Boutin implied that Frank Paul's life was of diminished value as a consequence of these factors. Although Sergeant Boutin wrote that his mitigating observations did not negate the wrongness of the officers' conduct, the fact that he saw fit to include these considerations in his written judgment is disturbing.
107. Section 19(1) of the Code of Professional Conduct Regulation under the *Police Act* lists the measures that can be taken where a disciplinary default has been committed by an officer. The high end of the spectrum begins with dismissal, reduction in rank, transfer or reassignment, and suspension without pay for not more than five working days. The low end of the spectrum includes direction to work under close supervision, direction to undertake special training or retraining, direction to undertake professional counselling, written reprimand, and verbal reprimand.
108. In addition to the options under the *Police Act*, the Vancouver Police Department had an internal policy of giving "management advice" to those officers whose conduct was not so serious as to warrant *Police Act* discipline, but who were believed to have acted inappropriately. Sergeant Boutin testified that at one point during his investigation, an IIS officer suggested to him that management advice would probably suffice for the mistakes that Sergeant Sanderson and Constable Instant had made.
109. The IIS Final Investigation Report was dated January 10, 2000 and concluded that the evidence was sufficient to justify the imposition of disciplinary measures against Constable Instant and Sergeant Sanderson. On February 10, 2000,

⁸¹ Boutin Transcript of Evidence, Feb. 12/08. p. 55

Sergeant Boutin submitted the report to Inspector Eldridge, and it was then forwarded to Chief Constable Blythe.⁸²

110. However, rather than ordering a formal disciplinary hearing, the Vancouver Police Department decided to utilize the “prehearing conference” procedures that are found in s.58 of the *Police Act*.
111. The prehearing conference procedures allow the discipline authority to offer the respondent a confidential, without prejudice, prehearing conference to determine whether the respondent is willing to admit to a public trust default, and if so, what disciplinary or corrective measures the respondent is willing to accept. Section 58 of the *Police Act* mandates that a prehearing conference must not be offered if it would be contrary to the public interest to do so.
112. The facts of Frank Paul’s death, and the actions of the officers involved, cried out for a public hearing. However, the Vancouver Police Department must be taken to have concluded that it would not be contrary to the public interest to have the matter dispensed with informally. Sergeant Boutin did not speak to whether any serious consideration was given to whether it was contrary to the public interest to resolve the discipline measures informally.
113. The prehearing conference report outlined the suspensions for each of the officers. Given the severity of the conduct at issue, the punishments were lax. Sergeant Sanderson was offered and accepted a 2-day suspension for failing to have Frank Paul medically assessed. Constable Instant was offered and accepted a 1-day suspension for failing to follow the orders of a superior.⁸³
114. The prehearing conference reported only the most basic reasons for the outcomes that the officers agreed to, and improperly relied on factors which have no relevance to discipline, including the fact that the Coroners Office did not order an inquest and the Crown did not lay criminal charges. If we are to rely on the prehearing conference report, it would seem that according to the Vancouver Police Department, Constable Instant’s only mistake was leaving Frank Paul in the wrong location.
115. Both officers obtained the help of others acting in some capacity as agents overseeing the implementation of punishment. Sergeant Sanderson had an active member in the police union advocating for him in the course of the investigation, attempting to lessen the suspension.⁸⁴ Constable Instant retained legal counsel throughout the process.⁸⁵
116. No attempt was made at remediation. With the implementation of the suspensions, there was no effort made to educate or inform the officers about

⁸² Boutin Transcript of Evidence, Feb. 12/08. p.150

⁸³ Boutin Transcript of Evidence, Feb.11/08, p.24

⁸⁴ Boutin Transcript of Evidence, Feb.12/08, p. 160-161

⁸⁵ Boutin Transcript of Evidence, Feb.12/08, p. 162.

proper conduct, despite the assertion found in the *Code of Professional Conduct* that “If the discipline authority considers that one or more disciplinary or corrective measures are necessary, an approach that seeks to correct and educate the police officer concerned takes precedence over one that seeks to blame and punish.”⁸⁶

117. After the 2-day and 1-day suspensions were imposed upon Sergeant Sanderson and Constable Instant, respectively, neither was subject to further disciplinary action, counselling, direction, or reprimand.

ii) The Vancouver Police Department Next of Kin Investigation

118. The investigation of the circumstances under which the Vancouver Police notified Frank Paul’s next of kin of his death was woefully inadequate. Inspector Rothwell stated that, in undertaking the investigation, the broad mandate was to establish exactly what was said and to whom by the police with regard to the death of Frank Paul.⁸⁷ In the same letter stating this mandate, Inspector Rothwell made no mention of the pertinent fact that members of Frank Paul’s family and band claimed they were never informed by the police of the fact that Frank Paul had been in police custody shortly before he died.⁸⁸

119. Unable to determine critical facts about the notification process, Inspector Rothwell blamed the band and Frank Paul’s relatives for the investigations failures. Inspector Rothwell asserted that “This investigation was frustrated by faded memories and an unwillingness by the members of the Big Cove Band Council and relatives of Frank Paul”.⁸⁹

120. Inspector Rothwell delegated to other constables the task of conducting the actual investigation.⁹⁰ Although Inspector Rothwell asserted in his findings to the Police Complaint Commissioner that Frank Paul’s relatives were unwilling to cooperate, he was unable to refer to any relatives in particular. He stated that his letter was merely attempting to convey a “sense of frustration felt by the investigators”.⁹¹ In actuality, it was found that in the documents pertaining to the investigation, nothing was written by the investigating members of the Vancouver Police Department stating that a specific relative of Frank Paul had been unwilling to cooperate.⁹² The documentary record discloses no unwillingness to co-operate. The VPD’s summary and assertions are, in short, misleading.

121. Inspector Rothwell went on to assert that he was satisfied that there was no credible basis for believing that members of the Band Council or Frank Paul’s

⁸⁶ Boutin Transcript of Evidence, Feb.12/08, p. 164-165

⁸⁷ Rothwell Transcript of Evidence, Feb.1/08, p. 20

⁸⁸ Rothwell Transcript of Evidence, Feb.1/08 p. 22

⁸⁹ Rothwell Transcript of Evidence, Feb.1/08, p. 22

⁹⁰ Rothwell Transcript of Evidence, Feb.1/08, p. 25

⁹¹ Rothwell Transcript of Evidence, Feb.1/08, p. 23

⁹² Rothwell Transcript of Evidence, Feb.1/08, p. 26

family had received “deceitful” information regarding the death of Frank Paul.⁹³ He made no mention of the fact the evidence suggested that members of Frank Paul’s family may have been under-informed of the circumstances surrounding Frank Paul’s death.⁹⁴

122. Frank Paul’s sister, Francis Jordain, stated that she had been informed by her aunt that her brother had been hit by a car and left in a ditch.⁹⁵ She was not contacted as part of the investigation to be asked how she found out about her brother’s death and what she was told. Inspector Rothwell himself stated that this gross oversight was regrettable, stating that taking such measures “could have been of tremendous value”.⁹⁶ Other relatives, including Frank Paul’s half brother, stated that they were told by police that Frank Paul had been killed in a hit and run accident.⁹⁷
123. Inspector Rothwell conceded that more could have been done in the investigation, by having investigators make more contact with Frank Paul’s family and in noting their responses more clearly. This opinion was reiterated by an investigating officer, Constable Legett.⁹⁸ Despite Inspector Rothwell’s finding that at least one person had been misinformed about Frank Paul’s death, he was not able to determine whether such misinformation was confirmed or contradicted by any police witness or record.⁹⁹

The Coroners Service

124. The Coroners Service of British Columbia failed to ensure that all the relevant facts pertaining to the death of Frank Paul were made a matter of public record. In doing so, it neglected to uphold the mandate of its agency.
125. The Coroners Service is responsible for the investigation of all unnatural, sudden and unexpected deaths in the province. The Coroners Service is a fact-finding body that publicly documents its work either through the completion of a Coroner’s judgment or the holding of an inquest, a quasi-judicial public hearing. One of the most important responsibilities of the agency is to advance recommendations to individuals, groups and agencies in order to prevent similar future deaths.
126. The Coroners Service determined that it would not order that an inquest with a jury to be held to determine the facts of Frank Paul’s death. Instead, the Coroner’s office issued a written Judgement of Inquiry, which relied almost exclusively on

⁹³ Rothwell Transcript of Evidence, Feb. 1/08, p. 31

⁹⁴ Rothwell Transcript of Evidence, Feb. 1/08, p. 31

⁹⁵ Rothwell Transcript of Evidence, Feb. 1/08, p. 42

⁹⁶ Rothwell Transcript of Evidence, Feb. 1/08, p. 47

⁹⁷ Rothwell Transcript of Evidence, Feb. 1/08, p. 80

⁹⁸ Rothwell Transcript of Evidence, Feb. 1/08, p. 37

⁹⁹ Rothwell Transcript of Evidence, Jan. 31/08, p. 139

the flawed investigation conducted by the Vancouver Police Department. By failing to use its investigative powers, and by accepting the Vancouver Police Department's homicide investigation report without critical analysis, the Coroners Service failed to uphold the public interest.

127. The *Coroners Act* in force in 1998 mandated that an inquest be held if a person died while detained by or in the actual custody of a police officer. The Coroners Service adopted an unduly narrow interpretation of its legislation and determined that Frank Paul's death was not "in-custody" death, and proceeded to prepare a Judgement of Inquiry. Frank Paul was at the mercy of Sergeant Sanderson and Constable Instant; he was unable to care for himself and had no ability to affect his circumstances. The officers that were responsibility for his well-being failed their duty of care. Given the circumstances, the Coroners Service ought to have considered Frank Paul's death to be an in-custody death governed by the mandatory duty to hold a public inquest.
128. Even if the Coroners Service was not mandated to hold an inquiry, it ought to have determined that an inquiry was appropriate in the public interest. Both Terry Smith, Chief Coroner, and Larry Campbell, former Chief Coroner, admitted that Frank Paul's case would have been better handled by way of inquest than by judgement of inquiry.¹⁰⁰
129. In preparing the Judgement of Inquiry, the Coroners Service relied almost exclusively in the flawed police investigation report and did not conduct independent research or investigation. Despite broad investigative powers that are granted to it under its constituting legislation, the Coroners Service did not conduct interviews of the respondent officers or other witnesses, did not seize documents, and did not collect information to assist it in determining the facts and circumstances of Frank Paul's death.
130. Neither Jeannine Robinson, the regional coroner, nor Donna Lister, the presiding coroner, conducted interviews with witnesses. Ms. Robinson accepted the statements of Constable Instant and Sergeant Sanderson despite the fact that their written statements conflicted with physical evidence at the scene of the death and the jail video that documented Frank Paul being dragged in and out of the jail.
131. Ms. Robinson admitted that based on the video evidence it was apparent that Frank Paul was intoxicated when he was released from the jail and dragged back to the wagon.¹⁰¹ Ms. Robinson testified that there were no efforts made by anyone in the Coroners Office to try and interview Sergeant Sanderson and get an answer to the obvious conflict between the video evidence that indicated that Frank Paul was drunk and Sergeant Sanderson's assertion that he was not.¹⁰²

¹⁰⁰ Smith Transcript of Evidence, Jan. 28/08, p.15; Campbell Transcript of Evidence, Jan. 25/08, p.85

¹⁰¹ Robinson Transcript of Evidence, Jan. 24/08, p.91-92

¹⁰² Robinson Transcript of Evidence, Jan. 24/08, p.92

132. The findings of fact in the Judgement of Inquiry recited the facts as set out in the written statements of the officers. Ms. Robinson uncritically accepted, and repeated verbatim, Constable Instant's written assertion that he left Frank Paul in a lane that was "sheltered on three sides," despite having personally viewed the alley and the photographs of the alley that indicated that no such shelter exists. In describing the condition Frank Paul was in when he returned to the jail for the second time, Ms. Robinson wrote that "Frank Paul was assisted into the jail elevator by the police officer," despite having viewed the video that clearly showed that Frank Paul was dragged, not assisted, into the jail by Constable Instant.¹⁰³
133. The Coroners Service was responsible for notifying Frank Paul's family of his death. The Coroners Service failed to notify his next of kin and failed to keep them informed as to its decisions. During the course of the Inquiry, the Coroners Service apologized to Frank Paul's family for its failure.¹⁰⁴
134. The Coroners Service failed to maintain the integrity of the Frank Paul file. The Coroners Service admitted that many key documents were missing from the file, including the medical certificate and the shipping certificate for Frank Paul's remains.¹⁰⁵ It seems likely that coroners' notes were also missing from the file. Despite an exhaustive search, the Coroners Service was unable to provide the Commission with a comprehensive file for its handling of the Frank Paul case. Deputy Chief Coroner Norm Liebel admitted that the Coroners Service file maintenance of the Frank Paul file was an "embarrassment."¹⁰⁶

The Police Complaint Commissioner

i) The failure of former Police Complaint Commissioner, Don Morrison, to order a public hearing.

135. The last viable opportunity for a full public airing of the events surrounding Frank Paul's death rested with the Office of the Police Complaint Commissioner (OPCC), and the then Police Complaint Commissioner, Don Morrison.
136. By the time the Frank Paul case reached the desk of Mr. Morrison, the Vancouver Police Department had concluded its criminal investigation, the Crown had decided not to lay charges, the Coroners Service had determined not to hold a Coroner's inquest, and the officers whose conduct had been at issue, Sergeant Sanderson and Constable Instant, were privately disciplined.
137. Approximately two years after the Vancouver Police Department assessed two and one day suspensions for the officers, Mr. Morrison advised the Chief of the Vancouver Police Department, by letter of January 18, 2002, that he would not

¹⁰³ Robinson Transcript of Evidence, Jan. 24/08, p.99

¹⁰⁴ Smith Transcript of Evidence, Jan. 28/08, p.12

¹⁰⁵ Liebel Transcript of Evidence, Jan, 29/08, p.8

¹⁰⁶ Liebel Transcript of Evidence, Jan, 29/08, p.9

order a Public Hearing under the Police Act and that no further action would be taken by the Police Complaint Commissioner.¹⁰⁷

138. The BCCLA agrees with the conclusion that the present Police Complaint, Commissioner Dirk Ryneveld, stated in his reasons for judgement. He wrote that Frank Paul's case "cried out for a Public Hearing to have been called in the first instance." The failure to order a Public Hearing rests with Mr. Morrison.

ii) The genesis of the failure to order a public hearing

139. The Vancouver Police Department initially notified the Police Complaint Commissioner of the Frank Paul case eight months after Frank Paul's death. The notification was in the form of a complaint laid by Sergeant Hobbs under s.52 of the *Police Act*. The complaint contained only cursory details about the police involvement in of Frank Paul's death.
140. Apart from one brief update that the Vancouver Police Department provided to the OPCC about its disciplinary investigation in 1999, the Vancouver Police Department did not provide the Police Complaint Commissioner with real details of the incident until June 2000 when it delivered its final investigation report to the OPCC. At that time, the *Police Act* investigation, despite its many inadequacies, was complete. The only *Police Act* decision left was whether to call a public hearing.
141. It is worth noting that the IIS Final Investigation Report was dated January 10, 2000, but the Police Complaint Commissioner was not given a copy of that report until June 2000. The *Police Act* requires the discipline authority to promptly provide a copy of the investigation report to the Police Complaint Commissioner. Considerable delay could have been avoided if the Vancouver Police Department had promptly provided the report.
142. The IIS Final Investigation Report included the entirety of the Sudden Death Report. Mr. Morrison requested that William MacDonald, an investigator at the OPCC, commence a review of the Final Investigation Report, including the Sudden Death Report.
143. Mr. MacDonald was the first person to review the Vancouver Police Department's criminal investigation of Frank Paul's death with a critical and objective eye. He should be commended for his thorough work and the diligence with which he approached his responsibility as a guardian of the public trust.
144. Mr. MacDonald completed his file review on August 18, 2000.¹⁰⁸ Mr. MacDonald documented a number of inconsistencies between the police respondents' stated beliefs about Frank Paul's level of intoxication and his capacity to care for

¹⁰⁷ Morrison Transcript of Evidence, Mar. 13/08. p.95

¹⁰⁸ Exhibit 152, Tab 16.

himself and other evidence.¹⁰⁹ He concluded that the respondents had a duty to care for Frank Paul; that Frank Paul could not care for himself due to his physical condition and state of intoxication; and that the respondents' neglect of duty resulted in Frank Paul's death.¹¹⁰ He further noted that the statement of Constable English that sets out that he counselled Constable Instant to abandon Frank Paul in the alley suggested that Constable English should properly have been named as a respondent and charged with a disciplinary default.¹¹¹ [note relevant?]

145. On the basis of his review, Mr. MacDonald strongly recommended that Mr. Morrison, pursuant to his authority as the Police Complaint Commissioner, should order a public hearing into the circumstances of the death of Frank Paul. He concluded that there was enough information on file to conclude that a public hearing was necessary, and that a public hearing would allow the public to reach a conclusion about the veracity of the officers' statements. Had Mr. Morrison acceded to the advice of Mr. MacDonald, there is the distinct possibility that in 2007, nearly 10 years after Frank Paul's death, it would have been unnecessary for the government of British Columbia to appoint an independent Commission of Inquiry.
146. Mr. MacDonald's report represented a complete and compelling justification under the Act for the holding of a public inquiry. Section 60(5) of the *Police Act* sets out the factors that the Police Complaint Commissioner is required to consider in deciding whether a public hearing is necessary in the public interest. The considerations are not optional – the Police Complaint Commissioner is mandated to consider all the factors, as well as any other relevant factors.
147. Mr. Morrison conceded on cross examination that all the factors he was mandated to consider were addressed by Mr. MacDonald in his file review.¹¹² The factors addressed by Mr. MacDonald that weighed strongly in favour of holding a public hearing were:
- (a) the complaint was serious because it involved a death associated with police conduct;
 - (b) Frank Paul died as a result of the conduct, and therefore the harm was of the most serious sort;
 - (c) there was a reasonable prospect that a public hearing would assist in ascertaining the truth because, amongst other things, an adjudicator could contrast the compellable testimony of certain witness officers against the written statements of Sergeant Sanderson, Constable Instant and Constable English;

¹⁰⁹ Exhibit 152, Tab 16.

¹¹⁰ Exhibit 152, Tab 16.

¹¹¹ Exhibit 152, Tab 16.

¹¹² Morrison Transcript of Evidence, Mar. 12/08. p.145

- (d) there were serious flaws in the Vancouver Police Department investigation;
 - (e) the penalties were likely inadequate given the evidence that the respondent officers were not truthful in their statements; and
 - (f) a public hearing was necessary to preserve public confidence in the complaint process.
148. On the basis of the information presented in Mr. MacDonald's file review, Mr. Morrison had more than enough evidence to conclude that holding a public hearing was necessary in the public interest. Yet Mr. Morrison was unwilling to make a decision at that time. He testified that he wanted better evidence, and more evidence.¹¹³
149. One might be reluctant to second-guess a decision that was made by an independent officer of the legislature, even one that seems patently misguided in hindsight. It is noteworthy, that even in retrospect Mr. Morrison would not concede that he had ample evidence at his disposal upon receiving Mr. MacDonald's file review to call a public hearing.¹¹⁴
150. There is compelling evidence that Mr. Morrison may not have considered some of the mandatory factors listed under Section 60(5) of the *Police Act*, and that he placed undue emphasis on irrelevant factors. Mr. MacDonald testified that Mr. Morrison, after reading the file review, was of the opinion that a public hearing should not be held. The reasons he gave for his opinion were that there had already been considerable delay, and because the respondent officers had already received suspensions and were not likely to receive greater punishment, a hearing would not serve a purpose.¹¹⁵
151. One of the irrelevant factors that Mr. Morrison's appears to have considered in the Frank Paul matter was the degree to which Frank Paul's death was not scrutinized by the media. Mr. Adie testified that, in general, Mr. Morrison partially based his decisions on whether or not to hold public hearings based on the media attention a complaint had received. Mr. Adie testified:

I can only say that having been Commissioner Morrison's deputy since the very beginning and I hope being reasonably astute at knowing my Commissioner's mind and his various opinions about things, it certainly was my – my perception that -- that it would be extremely unlikely that Commissioner Morrison would order a public hearing against the Vancouver Police unless the matter was in the media and there was very little other option.¹¹⁶

¹¹³ Morrison Transcript of Evidence, Mar. 12/08. p.149

¹¹⁴ Morrison Transcript of Evidence, Mar. 12/08. p148-149

¹¹⁵ Morrison Transcript of Evidence, Mar. 13/08. p.154-156

¹¹⁶ Adie Transcript of Evidence, Apr. 4/08. p. 76

....

[Y]ou'd be hard pressed to find a public hearing or an external investigation or anything like that ordered that wasn't already in the media. So that would be -- that would be my feeling about it, that there was -- there was very little appetite to be assertive in the matter of responding to complaints unless they were already on the six o'clock news.¹¹⁷

152. Another irrelevant factor that appears to have weighed in Mr. Morrison's decision not to hold a public hearing was the fact that Frank Paul ranked among the dispossessed. When asked in cross examination about that factors that contributed to Mr. Morrison's decision, Mr. Adie testified that the key factor was Frank Paul's anonymity and lack of social standing:

I think it had to do with the crux of him being a -- I don't want to be offensive, but a non-entity, not an important person in the scheme of things. He didn't belong to any organizations. He didn't belong to a union. He wasn't in the media. And that -- so he was just one more file passing through.¹¹⁸

153. Another irrelevant factor that appears to have weighed in Mr. Morrison's decision not to hold a public hearing was Mr. Morrison's desire to curry favour with the Vancouver Police Department. Mr. Adie testified:

I think that Commissioner Morrison was -- very anxious to have good relationships with the police unions and with the police executives, and only in my opinion I think he probably bent over too far in that direction to where he was not as assertive on the hands -- on behalf of the non-entities as he was in terms of the people that he met on a daily basis and broke bread with and had longer lasting relationships.¹¹⁹

154. Another irrelevant factor that appears to have weighed in Mr. Morrison's decision not to hold a public hearing was the impact that a public hearing would have on the respondent officers.¹²⁰
155. Mr. Adie was so disturbed by Mr. Morrison's handling of the Frank Paul file that after 27 years as a civil servant he resigned from his position at the OPCC. He stated that he "felt personally dishonourable to be associated with things that I thought were not to the standard of the code of conduct that I had lived with for 27 years."¹²¹

¹¹⁷ Adie Transcript of Evidence, Apr. 4/08. p. 77-78

¹¹⁸ Adie Transcript of Evidence, Apr. 4/08. p. 114

¹¹⁹ Adie Transcript of Evidence, Apr. 4/08. p.117

¹²⁰ See for example, Adie Transcript of Evidence, Apr. 4/08. p.136 and Morrison Mar.13/08. p. 156

¹²¹ Adie Transcript of Evidence, Apr. 4/08. p.96-7

156. Mr. MacDonald, Mr. Urban and Mr. Adie¹²² testified that from the outset, Mr. Morrison set his mind against ordering a public inquiry, and their subsequent efforts to obtain further evidence were efforts to persuade him to change his mind.
157. Mr. Adie testified that Mr. Morrison's attitude to the Frank Paul file "went from indifference to irritation over a period of time."¹²³ When asked what Mr. Morrison's approach to the Frank Paul file was, Mr. Adie stated:
- When staff members would say, "Well, you really have to look at this file or do something with this file," I think he -- he didn't -- as far as I can recall, he didn't express any particular interest or words around the file itself but really irritation with the matter being raised and expressed his irritation with the individuals who raised it.¹²⁴
158. Mr. Morrison testified that after reading Mr. MacDonald's file review, he was still undecided about whether he would order a public hearing, and remained open-minded as to the best way to proceed.¹²⁵ There are no documents created by Mr. Morrison or anyone else at the OPCC that memorialized his reaction to Mr. MacDonald's file review.¹²⁶ Mr. Morrison does not have an independent recall of any discussions about the file. The testimony of Mr. MacDonald, Mr. Urban and Mr. Adie, all of whom said that they had an independent memory of the events, are credible and should be preferred to the testimony of Mr. Morrison.
159. After Mr. MacDonald prepared his file review, and Mr. Morrison decided not to call a hearing at that time, there were a number of staff meetings in which it appears the Frank Paul file was discussed in a cursory manner.
160. It is difficult to know with certainty what directions Mr. Morrison gave concerning the Frank Paul matter and to whom, what conversations he had and when, and what agenda items he set for internal OPCC meetings concerning the matter, because Mr. Morrison did not keep minutes or draft memorandum.¹²⁷ He did not create any contemporaneous records of what he was thinking during the OPCC's handling of the Frank Paul matter, and he testified that he had very little independent recall, outside of the few documents that were maintained, of the steps that he took during the OPCC's handling of the Frank Paul matter, and why those steps were taken.¹²⁸ This lack of record keeping, in and of itself, raises legitimate concerns about the manner in which Mr. Morrison managed the OPCC.

¹²² For example, see Adie Transcript of Evidence, Apr. 4/08. p.76

¹²³ Adie Transcript of Evidence, Apr. 4/08. p.66

¹²⁴ Adie Transcript of Evidence, Apr. 4/08. p.66

¹²⁵ Morrison Transcript of Evidence, Mar. 12/08. p.106, p.123-4

¹²⁶ Morrison Transcript of Evidence, Mar. 12/08. p.106, p.115

¹²⁷ Morrison Transcript of Evidence, Mar. 12/08. p.106

¹²⁸ Morrison Transcript of Evidence, Mar. 12/08. p.104

161. The OPCC obtained a report from a forensic pathologist, Dr. Rex Ferris, in order to provide Mr. Morrison with an opinion about the circumstances of Frank Paul's death. The idea to retain Mr. Ferris was made at the initiative of Mr. Urban.¹²⁹ Mr. Morrison could not recall whose decision it was.¹³⁰ Dr. Ferris's report adduced that the facts were such that Frank Paul was likely suffering from hypothermia at the time he was admitted to the jail the second time. Mr. Morrison did not order a public hearing based on the new evidence.
162. Mr. Morrison's staff continued to try to persuade Mr. Morrison to hold a public hearing. In December 2000, Dana Urban, Counsel to the Police Complaint Commissioner, recommended to Mr. Morrison that the OPCC should refer the file to Crown Counsel for a decision as to whether or not they would consider commencing a reinvestigation based on the new evidence.
163. The Crown Counsel review took an additional 8 months, after which date the Crown reported to the Police Complaint Commissioner its decision not to proceed with criminal charges.
164. Mr. Morrison attached improper weight to the Crown decision not to lay charges against Constable Instant and Sergeant Sanderson. He testified that the Crown's decision not to lay charges was relevant to predicting whether an adjudicator would find that the respondent officers had formed the requisite mental state to warrant anything other than a suspension.¹³¹ The charging standard for a criminal offence is the substantial likelihood of conviction standard, which is founded on the criminal law standard of proof beyond a reasonable doubt. During examination, Mr. Morrison displayed an alarming lack of familiarity with the criminal charging standard, and it appears that his misunderstanding may have informed the weight he attached to the Crown's decision.¹³²
165. On August 21, 2001, Mr. Morrison convened a staff meeting in which one of the items for discussion was the Frank Paul file. Barbara Murphy made notes at the meeting. Her notes indicated that Mr. Morrison made a decision at the meeting not to order a public hearing.¹³³
166. Mr. Morrison did not make his decision public and the decision was not posted on the website, as was the ordinary practice. Mr. Morrison did not draft or make public any reasons for the decision. Mr. Morrison never wrote a formal letter to the complainant, the respondents or the disciplinary authority stating his decision not to hold a public hearing.
167. On August 30, 2001, Mr. Morrison attended a meeting with Vancouver Police Department officials Chief Constable Blythe and Sergeant Rothwell. He advised

¹²⁹ Urban Transcript of Evidence, Apr.2 /08. p. 21

¹³⁰ Morrison Transcript of Evidence, Mar. 12/08. p. 125

¹³¹ Morrison Transcript of Evidence, Mar. 12/08. p.70-71 [read this testimony]

¹³² Morrison Transcript of Evidence, Mar. 13/08. p. 71-73

¹³³ Exhibit 152, Tab 40

the police officials that he would not order a public hearing into the Frank Paul matter. Mr. Morrison could not remember if a member of his staff was also present. None of the OPCC staff that testified at the Inquiry recalled being present at the meeting. Mr. Morrison was unable to offer a satisfactory explanation as to why he did not make his decision public at the same time that he informed the Vancouver Police Department of his decision.

168. Mr. Morrison attempted to convince other government officials to do what he was unwilling to do himself: call for a public airing of the facts and circumstances of Frank Paul's death. He was not successful. He requested that the Chief Coroner reconsider holding an inquest, but the Chief Coroner declined to do so.¹³⁴ He asked the Solicitor General to order a Coroner's inquest, but the Solicitor General declined to do so.¹³⁵
169. On January 15, 2002, Mr. Morrison closed the Frank Paul file at an OPCC staff meeting.¹³⁶ He advised the Chief of Police that the file had been closed by letter dated, January 18, 2002.¹³⁷
170. Mr. Morrison's decision not to hold a public hearing was not made public until a summary of the Frank Paul case was published in Police Complaint Commissioner's 2001 Annual Report.¹³⁸ The 2001 Annual Report was released at some point in 2002.¹³⁹ By that late date, Mr. Morrison had resigned from the office.

iii) The Actions Taken by Police Complaint Commissioner Dirk Ryneveld

171. In April 2002, the legislature convened a Special Committee to Review the Police Complaint Process. In the wake of revelations that came to light during the testimony that was given before the Special Committee, the Frank Paul case became the subject of intense public scrutiny.
172. Subsequent to the proceedings of the Special Committee, the OPCC received two "third party" complaints regarding the Frank Paul case. In July 2002, Mr. Kelliher, counsel for the Frank Paul family, requested that the Frank Paul family be provided with the jail video tape. In July 2002, the BCCLA requested that then Acting Police Complaint Commissioner Ben H. Casson publicize the details of the Frank Paul case. In July 2002, the United Native Nations Society lodged a complaint with the OPCC regarding Frank Paul's death.
173. Police Complaint Commissioner Ryneveld took office in February of 2003, and after an extensive review of the file, decided to reopen the Frank Paul case. He

¹³⁴ Morrison Transcript of Evidence, Mar. 12/08 p.87

¹³⁵ Morrison Transcript of Evidence, Mar. 12/08. p.90

¹³⁶ Exhibit 152, Tab 52

¹³⁷ Exhibit 152, Tab 53

¹³⁸ Exhibit 152, Tab 55

¹³⁹ Morrison Transcript of Evidence, Mar. 12/08. p.6

made his decision based on of new evidence that had come to light and revelations about the unsatisfactory communications that the Frank Paul's family had had with the Vancouver Police Department concerning the manner in which Frank Paul died. Commissioner Ryneveld's bold decision should be commended in the most uncertain terms. Commissioner Ryneveld's action was the proper course of action and served the public interest.

CONCLUSION ON THE ADEQUACY OF THE RESPONSE TO THE DEATH OF FRANK PAUL

Vancouver Police Department

174. The response of the Vancouver Police Department to the death of Frank Paul was wholly inadequate and fundamentally flawed, from its inception to its conclusion. In short, from the inadequacy of the initial response and scene containment on December 5, 1998, to the inaccurate information disseminated at the public forum on April 28, 2007, the Vancouver Police Department has completely failed Frank Paul.
175. Much has been said during the course of these proceedings and in oral submissions about the inadequacy of the major crime section investigation, and those submissions will not be repeated here. It is evident, particularly from the evidence of Detective Staunton, that there were flaws within the major crime section investigation. The BCCLA goes further and submits that there is a fundamental flaw in the manner in which the Vancouver Police Department routinely investigates police involved deaths. Of course, it will ultimately be the submission of the BCCLA that the Vancouver Police Department should not have conduct of such investigations, but rather a system of civilian oversight and investigation should be put in place. Furthermore, it is the position of the BCCLA that the practice of preparing "neutral reports" with respect to police involved deaths is not sound in principle or in practice.
176. With respect to the Internal Investigation Section, the BCCLA submits that it conducted virtually no investigation whatsoever, and chose instead to rely upon the fruits of the major crime investigation. Moreover, the BCCLA submits that the manner in which the disciplinary defaults were informally dealt with and the length of suspensions meted out was inappropriate and inadequate. Finally, the BCCLA submits that the absence of any remediation within the disciplinary process rendered same virtually meaningless.
177. With respect to the Coroners Service, the BCCLA submits that they failed in their function to utilise their own investigative powers, and chose merely to rely on the fruits of the major crime investigation. Moreover, the Coroners Service took an unduly restrictive view of the meaning of "in custody" death in failing to order a mandatory inquest. Finally, it is submitted, the Coroners Service erred in failing to order a discretionary inquest into the death of Frank Paul.

178. However, the BCCLA is somewhat heartened by the following facts:
- (a) Mr. Larry Campbell, then Chief Coroner for British Columbia, agreed that with the benefit of hindsight, an inquest should have been held;
 - (b) Representatives of the Coroners Service have stated that, were the circumstances to be repeated today, an inquest would be held;
 - (c) The Coroners Service has admitted certain mistakes which were made on this file;
 - (d) The Coroners Service has represented to this Commission that they could work quite well with some form of civilian special investigation unit.
179. The office of the Police Complaint Commissioner as it existed up to the commencement of Mr. Rynveld's term, failed Frank Paul. Former Commissioner Morrison acknowledged that he believed the discipline to be inadequate, but he failed to order a public hearing. The BCCLA submits that many of his reasons for failing to do so were based on extraneous considerations. It is submitted that he failed to consider the main criteria which he was obliged by statute to consider. Moreover, he acknowledged that he knew he was the person with the final opportunity to ensure that there was a public airing of the circumstances surrounding Mr. Paul's death, and yet he chose to close his file. In so doing, his response and, by extension, that of his office, to the death of Frank Paul was entirely inadequate.
180. With respect to the Criminal Justice Branch, as noted in oral submissions, they have chosen not to meaningfully participate in these hearings, and as such, little can be said about their response to the death of Frank Paul. The individuals at the Criminal Justice Branch who made the charge assessment decisions in the Frank Paul case should have testified as to what they did, what materials they reviewed, what decisions they made and the reasons for those decisions so that the Frank Paul's family and the public could arrive at a fair conclusion about their conduct. That they refused to do so is disturbing.

Recommendations for Change

Overarching Recommendations

181. The BCCLA respectfully submits that this Commission should consider broad recommendations in the area of decriminalisation of intoxication. We have all had the benefit of a very enlightened and informative presentation by the Aboriginal Legal Services of Toronto dealing, in part, with initiatives which could be taken in this regard. It does not appear from oral submissions that any of the participants in this Inquiry oppose what can be broadly referred to as the decriminalisation of intoxication. The Vancouver Police Department has taken the position that it welcomes means other than police wagon to transport acutely intoxicated people to places other than the Vancouver City jail, namely a properly staffed and funded

sobering centre. All other participants who made submissions in this area have advocated for same.

182. Secondly, the BCCLA submits that this Commission of inquiry should recommend that in cases involving death or serious injury in which the police are involved or implicated, that the police not investigate themselves. In short, that a system in part modelled on the Ontario Special Investigation Unit be created and implemented in British Columbia, to the extent possible. We advocate a system of civilian oversight at both the investigative stage and the disciplinary stage. With respect to the latter, we note that counsel for the present Police Complaint Commissioner takes the position that the OPCC could work quite comfortably with an organisation such as the SIU, provided that there was a mechanism for sharing the fruits of investigations.
183. The BCCLA adopts the submission of counsel for the Police Complaint Commissioner with respect to the ability of this Commission to recommend legislative change, where such changes are inherently necessary in order to effect changes to the rules, policies or procedures of the various institutional bodies referred to in the terms of reference.
184. However, the BCCLA parts company with the OPCC on the issue of the degree of deference which ought to be paid to the recommendations made in the February 2007 “Report on the Review of the Police Complaint Process in British Columbia” [The Wood Report]. Insofar as the Wood Report does not recommend the creation of a civilian investigation unit, the BCCLA respectfully disagrees. It is our position that the time has clearly come for the creation of a civilian investigation unit to investigate all cases of police involved death or serious injury. We rely on the presentation of André Marin and Gareth Jones in this regard, which we submit amply and effectively demonstrated the potential effectiveness of such an organisation, the cost effectiveness of same, and, most importantly, the societal benefit which derives from an entirely impartial body conducting such investigations.

Discrete Recommendations

i) Vancouver Police Department

185. If the Vancouver Police Department is to continue transporting and occasionally housing severely intoxicated people, the BCCLA respectfully submits that the following recommendations should be made with respect to the policies and protocols at issue:
- (a) The Vancouver Police Department should undertake better and more intensive training of recruits as it relates to dealing with individuals they will encounter within the downtown eastside, specifically the homeless, the impoverished, the mentally unstable and the chronically alcoholic. It is clear from Constable Instant’s evidence that his training did not

adequately prepare him for the realities of dealing effectively with those he would encounter on the downtown eastside.

- (b) The Vancouver Police Department should examine what appears to be its informal policy of having the most junior officers on a given shift operate the wagon. An officer more senior than Constable Instant might have found a way to meaningfully question Sergeant Sanderson's order in a way which would have led to better decision making. Moreover, the Vancouver Police Department should develop an express written protocol for questioning an order of a superior officer which leaves a junior officer confused or in doubt, as Constable Instant testified he was.
 - (c) The Vancouver Police Department should alter their policy with respect to H/SIPP arrests as it relates to so-called violent detainees. Only those individuals who are violent at time of arrest should ever be transported to jail as opposed to the detox centre. Individuals such as Frank Paul who have a CPIC entry for violence should not be routinely taken to jail simply on that basis. Moreover, Saferide should be called for all individuals who are not exhibiting violent behavior at time of arrest. There should be no discretion with the individual officers as to means of transport and deciding who goes to detox and who goes to the jail. Finally, even those individuals exhibiting mildly violent behaviour should be taken to detox to determine if detox staff will accept them or not.
186. If, in police involved deaths, the police continue to investigate themselves, the following policy and/or procedural changes ought to occur:
- (a) The police should immediately notify Crown Counsel that an investigation has commenced.
 - (b) As a matter of routine, the Vancouver Police Department should notify the office of the Police Complaint Commissioner and request that any and all investigations be conducted by an outside police force.
187. With respect to the internal disciplinary process of the Vancouver Police Department, if they are to continue investigating their own members, it is submitted that the following recommendations should be made for changes to their policies and/or practices:
188. The internal investigations section should conduct its own investigation, separate and apart from that of the major crime section or other investigative body dealing with the police involved death.
189. In all cases of discipline involving punishment other than termination, in addition to any disciplinary measure, there should be documented measures of remediation, including, but not limited to, mandatory retraining in the area of concern.

ii) Coroners Service

190. If an SIU model is not implemented in British Columbia, the Coroners Service, it is submitted, ought to conduct its own independent investigation into a police involved death, as opposed to merely relying on the fruits of the major crime investigation.
191. Further, it is submitted that the Coroners Service ought to be encouraged to create a more rigid protocol for following-up on what steps, if any, various bodies take in response to Coroners Recommendations.

iii) Office of the Police Complaint Commissioner

192. The primary submission of the BCCLA is that a model akin to the SIU system in Ontario be implemented in British Columbia. If such is not to occur, the fallback position of the BCCLA is that the OPCC must be given broader and more clearly defined investigatory powers in order to fulfil its mandate as a meaningful vehicle for police oversight. The BCCLA would prefer to make further comment on this, if at all, following a review of the submissions of the OPCC.

iv) The Criminal Justice Branch

193. Although the extent of participation of the Criminal Justice Branch is not yet resolved, the BCCLA wishes to make one submission with respect to changes to the policies and practices of the Criminal Justice Branch, namely that in all cases of police involved death or serious injury, a special prosecutor be immediately assigned to the case. He or she would then be responsible for exercising some supervisory role over the investigation and also making the ultimate charge approval decision. At a minimum, such a step would allay any public concerns about a perception of bias with respect to Vancouver Crown Counsel making charge approval decisions in relation to VPD members.

Conclusion

194. The BCCLA is grateful to this Commission for granting it participant status in these important proceedings. We have endeavoured to participate as fully and constructively as possible. We sincerely hope that these submissions provide some assistance to counsel and the Commissioner as they now undertake a most daunting and important task. It is our hope that constructive change to the way in which society's most disenfranchised people are treated will be effected through the work of this Commission, and that such will be the legacy of Frank Paul's brief and often painful life.