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BC Civil Liberties Association

**POLICE-INVOLVED
DEATHS**

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Police-Involved Deaths

The Failure of Self-Investigation

Final Report

David MacAlister
Principal Researcher for the
B.C. Civil Liberties Association

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Kevin St. Arnaud, Robert Dziekanski, Ian Bush, Frank Paul and Paul Boyd: Police-Involved Deaths in British Columbia

Kevin St. Arnaud

Factual Background



In late 2004, Cst. Ryan Sheremetta investigated a break-in at a pharmacy in Vanderhoof, B.C. Upon Cst. Sheremetta's arrival, Kevin St. Arnaud was witnessed running away from the scene of the break in. After a brief pursuit, Cst. Sheremetta confronted Mr. St. Arnaud on a nearby soccer field. At that location, Cst. Sheremetta shot Mr. St. Arnaud three times, resulting in his death. Cst. Sheremetta claimed he shot in self-defence. Cst. Sheremetta said that during the incident he slipped and fell onto his back and fired up at Mr. St. Arnaud whom he said was advancing on him. However, the available forensic evidence and the witnesses at the scene did not back up this version of events. One of the witnesses was Cst. Sheremetta's partner, Cst. Colleen Erickson. She said Cst. Sheremetta fired at St. Arnaud while standing up, with his feet apart, in a police combat stance. Mr. St. Arnaud was not armed at the time of the incident. Cst. Sheremetta was not charged with any offences arising out of the incident.

Inquiries

A coroner's inquest was held in January of 2007. At this inquest, the jury heard that St. Arnaud was highly intoxicated at the time of the incident. The incident was also the subject of a self-initiated complaint by the Commission for Public Complaints Against the RCMP. In 2007, the Commission for Public Complaints concluded the RCMP investigation into St. Ar-

naud's death was inadequate and not impartial in some regards. It also concluded the investigation failed to properly follow the appropriate major case management process. However, the Commission found Cst. Sheremetta acted in self-defence. The investigative television show W5 looked into the St. Arnaud shooting in 2009 and concluded the finding of the Complaints Commission appeared to fail to account for the inconsistencies between Cst. Sheremetta's account of the event and the facts arising from the forensic evidence and his partner's evidence.

Lessons Learned

Police investigators should not be involved in the investigation of other police officers in that same agency who have been involved in serious incidents such as shootings. The assessment of whether to lay charges against police officers should be a decision made independent of the Criminal Justice Branch of the provincial Crown Counsel office.

Robert Dziekanski

Factual Background



Robert Dziekanski was a Polish immigrant who died in the arrival area of the Vancouver International Airport after RCMP officers used a Taser electric stun gun on him. Mr. Dziekanski wandered around the customs and baggage area for international arrivals at the airport for six hours on Oct. 14, 2007. He was unable to

communicate effectively with anyone because he did not speak or understand English and no one working in that area of the airport spoke Polish. While he wandered this area of the airport, his mother awaited him beyond the secure area he was in, but she was unable to contact him. Eventually, Mr. Dziekanski was processed through the secondary customs check at the airport, where he was granted landed immigrant status. During this time, Mr. Dziekanski had several interactions with various border services officers; however, communication remained a problem. He appears to have become confused and agitated during the latter portion of the many hours spent at the airport. Four police officers arrived on the scene and attempted to gain control over him. In the process, one of the officers applied the Taser several times. Mr. Dziekanski was forced to the ground by the electric shocks, where the police put him in restraints. He died a few minutes later.

Inquiries

Provincial Crown prosecutor Stan Lowe decided no charges should be filed against the police officers involved in the incident. The B.C. provincial government established a commission of inquiry, headed by former justice Tom Braidwood. That commission is still in the second phase of its inquiry. The first phase looked into the use of conducted energy weapons. The second phase is looking into the circumstances of Mr. Dziekanski's death. A report on the first phase of the inquiry was released in June 2009. In addition, the Commission for Public Complaints Against the RCMP launched a self-initiated complaint into the event. A report on this was released in October 2009.

Lessons Learned

Police Taser use policy should be more tightly controlled. Police agencies should not self-investigate. Police training needs considerable improvement, both in regard to the use of Tas-

ers and in regard to dealing with emotionally upset individuals. Proper warnings should be given prior to deployment of the Taser. Multiple cycling of the Taser should be avoided. Proper medical care must be provided to individuals brought into police custody. Independent prosecutors should determine whether charges against the police should be filed.

Ian Bush

Factual Background



Ian Bush was confronted by a police officer for drinking beer in public outside a hockey arena. He provided a false name and was brought into custody and transported to the RCMP detachment in Houston, B.C. While being processed, Ian Bush was

shot in the back of the head by the arresting officer, Cst. Paul Koester, a 28-year-old rookie officer. Cst. Koester claimed he was forced to shoot Bush in self-defence because the young man attacked him and began choking him while he was trying to process him out of custody. At the time of the altercation, the two individuals were alone in an RCMP interview room.

Inquiries

A coroner's inquest was held in regard to the fatal shooting. At the inquest, the arresting officer's version of events was contrary to forensic evidence provided by a police blood spatter expert. The coroner's jury recommended that officers not be alone with suspects until they are housed in a cell, and that audio-video monitoring equipment should be present in all police interview rooms. Mr. Bush's family filed a civil law suit questioning how he could have been shot from behind if he was attacking Cst. Koester as the officer claimed. That civil suit was subsequently abandoned. The Chair of the Commission for Public Complaints Against the

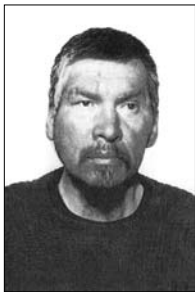
RCMP self-initiated a complaint into the actions of Cst. Koester. He issued a report in November 2007 that cleared the involved officer.

Lessons Learned

The police should not investigate themselves. Police should not be armed when booking individuals into police cells. More than one officer should be present in booking areas.

Frank Paul

Factual Background



Frank Paul was picked up by the Vancouver police in December 1998 for being drunk in a public place. After his arrest, a sergeant at the city “drunk tank” refused to take him in. As a consequence, he was dragged to a police wagon and transported

to a nearby alley where he was dumped and abandoned. Mr. Paul subsequently died in the alley from hypothermia. Mr. Paul was a New Brunswick Mi’kmaq native, who had a lengthy history of homelessness and alcoholism.

Inquiries

The province commissioned retired judge William Davies to conduct an inquiry into the death of Frank Paul. In February 2009, he released his report. That report was highly critical of police conduct in relation to the incident.

Lessons Learned

Cities should have facilities other than jail cells to hold individuals found intoxicated in public. Police should not abandon intoxicated individuals to the city streets. Police owe a duty to care to those individuals who are brought into their custody. Vancouver must do more to address the needs of the chronically homeless.

Paul Boyd

Factual Background



In the summer of 2007, Paul Boyd was shot to death on a busy downtown street by Vancouver police. Mr. Boyd was swinging a heavy chain and padlock at the officers who were trying to arrest him. According to witnesses, as many nine shots were fired

at Mr. Boyd by police, resulting in his death. Paul Boyd had been a successful animator; however, he was diagnosed with bipolar disorder in his mid-20s and suffered from paranoid delusions. He may have been suffering from one of these delusions on the night he was killed.

Inquiries

The Vancouver Police Department’s professional standards unit conducted an internal investigation, and the RCMP’s Integrated Homicide Investigation team oversaw the investigation. The B.C. Civil Liberties Association also recently lodged a complaint to the B.C. Police Complaint Commissioner on Boyd’s behalf. A coroner’s inquest is scheduled to commence in August 2010.

Lessons Learned

Police need additional training to deal with mentally disordered individuals. Police need to take full advantage of less than lethal alternatives before resorting to deadly force.

Chapter 1

Police-Involved Deaths: Introduction

Police-involved deaths have attracted considerable media and public attention in recent years. Few issues involving the conduct of government are of such significance as those arising in this context. In order for the government to maintain legitimacy, there must be clear and effective oversight of such matters to maintain public confidence in the government in general, the criminal justice system more particularly, and especially in the police.

A 2009 Angus Reid poll found that, amongst British Columbians, 61 percent of those surveyed indicated their confidence in the RCMP had declined (CTV News, 2009). This decrease in confidence followed on the heels of a number of incidents involving alleged police wrongdoing, including several incidents in which individuals died in police custody.

This report focuses on deaths in actual police custody. However, some cases involve similar issues although the individual is not in actual custody. For example, Frank Paul was not in actual police custody at the time of his death, yet his death after being deposited and abandoned in an alley by police clearly merits attention in the same context as deaths that actually arise in police custody. When the police take individuals under their charge, they are required to provide them with an adequate level of care.¹

An area of substantial concern is the risk of suicide involving detainees in police custody. Factors increasing the risk of suicide in custody have been documented in recent years:

Persons who die by suicide in jails have been consistently shown to be young, white, single, intoxicated individuals with a

history of substance abuse. Suicide in correctional facilities generally occurs by hanging, with bed clothing most commonly used. It is not clear whether first-time non-violent offenders or violent offenders are at greater risk. Most but not all investigators have reported that isolation may increase suicide in correctional facilities and should be avoided. While inmates may become suicidal anytime during their incarceration, there are times when the risks of suicidal behaviour may be heightened. Experience has shown that suicidal behaviours increase immediately on entry into the facility, after new legal complications with the inmate's case (e.g., denial of parole), after inmates receive bad news about loved ones at home, or after sexual assault or other trauma (Jacobs, et al., 2003, p. 49 references omitted).

The law requires the police take reasonable steps to prevent harm, including suicides while a person is detained in custody. Where the police are aware an individual is a suicide risk, they must take appropriate steps to prevent the occurrence of self-harm.² The police are also obligated to ensure adequate medical care is obtained for individuals being detained who require it.³ The courts have also been vigilant in demanding that the police take care when bringing a person into police custody that they do not unnecessarily injure the person.⁴ Given the legal obligations on the police, it is essential that they engage in practices and develop policies that conform to their legal and moral obligations.

One would hope that individuals with medical conditions, drug or alcohol addictions, or those at risk of suicide who find them-

selves in police custody would be at reduced risk of harm than they would be if left at large in the community. Yet many of these at-risk individuals die while in police custody.

This report seeks to gain a better understanding of police-involved deaths, and to provide specific recommendations to address how to prevent these incidents from arising, and how to best address investigations into these deaths. Furthermore, it sets out a model of investigation and oversight that ensures a sufficient degree of accountability will be obtained.

The report commences with a look at the death in custody phenomenon itself. Fairly little is known about police-involved deaths in Canada. There has been very little academic attention given to this topic, and government agencies do not routinely reveal much information regarding deaths arising through police contact. The public tends to garner a snap shot of these incidents only periodically, when cases attract media attention. Accordingly, the next chapter reveals the results of an attempt to garner information from coroners' offices across the country.

Chapter 3 looks at the problem of the way in which allegations of serious police wrongdoing are investigated. Deaths in custody and other serious injuries are routinely investigated to determine whether wrongdoing occurred, and if so, whether anyone should be charged with an offence. Historically, this has involved the police carrying out an investigation on themselves. Usually, an "internal affairs" or "professional standards" unit within a police agency conducts an investigation into a police involved death. In recent years, most jurisdictions have begun to move towards external investigation, so the investigation is not carried

out by the police agency under scrutiny. This external investigation is necessary to abate concerns of the appearance of bias that flow from self-investigation. However, some jurisdictions have gone to greater lengths than others in developing processes to carry out fair, unbiased investigations of alleged police impropriety.

Chapter 4 seeks to develop an understanding of why there seems to be so little advancement towards a model of police investigation in which an external civilian agency with civilian investigators carries out the investigation of alleged police wrongdoing. The police themselves seem particularly reticent to the idea of having non-police officers control the process of investigating allegations that a police officer has done something wrong.

Chapter 5 outlines the essential components of a model system for the investigation of allegations of serious impropriety by the police. Such a system must be external to the agency being investigated. It must be civilian-led and be composed of well trained civilian (non-police) investigators. The agency responsible for these investigations must be open, transparent and accountable. It must have sufficient powers, and be given sufficient resources to fulfil its mandate. It must also be free to refer the results of its investigations to an independent prosecutor to determine whether charges should be pursued.

The final chapter looks at prevention. Clearly, the best way to deal with police-involved deaths is to reduce the number of deaths that arise in that context. In an ideal world, no one would die in police custody. While that ideal may be unattainable, it is incumbent on society to ensure that every effort is made to reduce the number of deaths to as few as possible.

Chapter 2

Police-Involved Deaths: A Review

Despite the important nature of the phenomenon, and considerable public concern over the matter, very little is known about police-involved deaths in Canada. What little is known comes from a variety of sources. In order to get a picture of the death in custody phenomenon, the existing literature will be summarized, followed by a look at data obtained from coroners across the country through an access to information request.

Literature Review

i. Police and Official Government Sources

Canadian police attempt to manipulate their image through the media to appear in the best possible light (Ericson, 1989, Ericson et al., 1991, Ericson et al., 1989). Accordingly, police sources of information on this topic must be viewed carefully. The principal Canadian police source of information on deaths in custody in recent years is an internal report (RCMP, 2007) that was released under an access to information request by a news media source (CBC News, 2008).

The 2007 RCMP report on in custody deaths found the majority of deaths occurred at the scene of the call. In summary, it found:

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

with the police. Deaths in RCMP cells declined during the period from 2002 to 2006, which speaks to the effectiveness of RCMP efforts to improve cell design and implement more rigorous monitoring of prisoners (RCMP, 2007, p. 3).

In addition to the general decline in the number of in custody deaths, the report also found that none of the most recent deaths were preventable, implying that recent policy reforms by the RCMP were having the effect of reducing deaths in custody attributable to police conduct.

Critics have noted that the report reveals a disproportionate number of police-involved deaths arise in British Columbia (CBC News, 2008). The report has also been critiqued for failing to reveal the characteristics of the officers involved in these deaths, instead focussing on the characteristics of the victim (CBC News, 2008).

Prior to 2006, the RCMP “in-custody death” reporting scheme did not include data pertaining to deaths arising from police officers shooting and killing an individual. These cases were classified as involving individuals who were not “in-custody” and accordingly were excluded. From 2006 onwards, the data includes such cases, and the 2007 report incorporated “member-involved shooting” deaths even though the RCMP did not technically classify all such deaths as “in-custody” throughout the reporting period. The report identified almost a quarter of the deaths (19 out of a total of 80) as resulting from member-involved shootings. After alcohol/drug overdose, shooting was the second largest cause of death category in the analysis. The report claimed all of the incidents of police shooting that resulted in death were in accor-

dance with police policy and statute. However, among the incidents arising during the report period are controversial cases, including the in-custody shooting death of Ian Bush in 2005.

In 2007, the US Bureau of Justice Statistics released a report on arrest-related deaths in the US (Mumola, 2007). This report arose due to the reporting mandate imposed through the passage of the *Death in Custody Reporting Act of 2000* by the US Congress.⁵ This report looked at over 2000 arrest-related deaths in the US over a three year period. The most frequent cause of death was homicide by a police officer (accounting for 55% of the deaths), followed by drug and alcohol intoxication (13%), suicide (12%), accidental injuries (7%), and other causes or illness (6%). For 8 percent of the cases, no definitive cause was identified. A supplementary table published in 2009 revealed an additional 710 arrest-related death cases for 2006, an even higher number than for any of the years in the initial report (Mumola and Noonan, 2009).

The Bureau of Justice Statistics report noted that deaths due to the use of conducted energy weapons (CEW, also known as “taser”) rose significantly during the study period. These weapons were associated with 36 arrest-related deaths during the study period, rising from 3 in 2003 to 9 in 2004 and 36 in 2005. The report indicated that the conducted energy weapon had been identified as the cause of death in 1 of the incidents (Mumola, 2007, p. 4). The report indicates that due to gaps in reporting, these numbers do not reflect the total number of CEW-related deaths at the hands of police. In addition to police taser use, the report noted that police use of firearms played a key role in many of the deaths covered by the report. A full 96 percent of the homicides by police officers involved those officers using firearms against subjects. In 80 percent of the homicides by police officers, the arrest subject used a weapon to threaten or assault the police.

The Bureau of Justice Statistics report noted that deaths arising from suicide increased over the study period from 56 in 2003 to 91 in 2005. Suicides were also the only manner of death in which the majority of the subjects were white (Mumola, 2007, p. 5).

ii. Commissions of Inquiry

Numerous formal inquiries by government-sponsored commissions have either touched on or focussed intently on police-involved deaths.

1. *Australian Royal Commission into Aboriginal Deaths in Custody: National Report*

Australia was a pioneering jurisdiction with regard to its government’s commitment to formally inquire into police-involved deaths, establishing a royal commission in 1987 which looked at issues pertaining to aboriginal deaths in custody, ultimately reporting to their federal Parliament in 1991 (Johnston, 1991).

The Royal Commission looked at aboriginal deaths in both prisons and police lock-ups. It found aboriginals to be significantly over-represented in deaths in police lock-ups more so than in prisons. The Commission issued hundreds of recommendations for reform. Among the major calls for change was a recommendation to decriminalize a number of minor offences that were resulting in aboriginals being picked up by the police in the first place – particularly for offences such as public intoxication. Another notable recommendation was for the provision of alternatives to lock-ups for many detainees, such as the creation of “sobering up facilities” staffed by health care personnel. Additionally, a number of specific recommendations for changing the lock-up regime were advanced, such as eliminating “hanging points” from cells, increasing cultural sensitivity, improving assessment procedures for those being booked into cells, and increased recognition of the duty of care owed to detained subjects by detaining authorities.

Recent academic literature commenting on the effect of the Australian Royal Commission has lamented the lack of change in that jurisdiction and the unwillingness of police authorities to embrace reform. Cunneen (2008) noted that Australia took a punitive turn in the 1990s, which has resulted in ongoing systemic targeting of aboriginals by the Australian justice system. He also noted that the hundreds of recommendations made by the Commission in 1991 have largely been ignored (Cunneen, 2006).

In 2004, an aboriginal man, referred to as Mulrunji, died in police custody on Palm Island in Queensland, Australia. He died in circumstances that called into question whether the Royal Commission had had any positive effect. The victim died in police cells, having suffered serious bodily injury; however, the officer responsible for taking him into custody was subsequently acquitted of any wrongdoing (Corrin and Douglas, 2008). A riot on the island followed the public release of information regarding the circumstances of the victim's death (Todd, 2004).

While police-involved deaths are clearly an ongoing problem in Australia, a report released in 2001 indicates significant reductions in the number of police-involved deaths in the ten year period following the issuance of the Royal Commission's report when contrasted with the ten year period immediately preceding the release of the report (Williams, 2001). From 1990-1999 21 aboriginals died in police custody, contrasted with 67 from 1980-1989 (p. 2). A similar decline in the number of non-aboriginals dying in police custody was found in the more recent time period. Despite this positive outlook, the number of aboriginal people dying in prisons increased from 39 to 93 between 1990 and 1999.

2. Policing in British Columbia – the Oppal Report

In 1994, Justice Oppal of the B.C. Court of Appeal (as he then was) conducted a broad re-

view of policing in B.C. Included in his two-volume report were recommendations for reform of the complaints and discipline process for all police officers in B.C. Among the various recommendations were calls for reform of the way investigations of allegations of serious police wrongdoing are carried out.

It was recommended that B.C. adopt a civilian complaint commissioner (which it has done), with the authority to supervise investigations of complaints with cooperation from police investigators. It was further recommended that the complaint commissioner have power to actually conduct investigations, and to call police investigators to account where investigations were left in their hands. It was envisaged that the complaint commissioner's office would have a staff of well-trained investigators. These latter recommendations did not come to fruition. Justice Oppal also recommended that the new process of investigation and oversight be applied to all police officers in the province; however, the RCMP, whether operating as a federal force or under contract as a provincial or municipal force, has remained outside the jurisdiction of the police complaint commissioner in B.C.

3. Report of the Review on the Police Complaint Process in B.C. - the Wood Report

In 2007, former B.C. Supreme Court Justice Josiah Wood released a report for the B.C. government that involved a review of a number of police complaint files. Unfortunately, none of the files that he reviewed involved in-custody deaths. Despite this, Mr. Wood made a number of recommendations for reform to the B.C. complaints system that pertains to municipal police which are of relevance.

The Wood Report found numerous cases involving allegations of excessive use of force by the police that suffered from material defects in the process that was applied. His audit of

complaint cases revealed the police frequently violated the law, yet complaints were routinely dismissed. The Wood Report concluded that enhanced civilian oversight through the Office of the Police Complaint Commissioner is needed to improve the complaint process regarding municipal police in B.C.

The report fell short of recommending the complete removal of the police complaint investigation process from police hands. Instead, the recommended reforms sought to improve the existing system by addressing its most obvious deficiencies. However, the report concluded with a caution that should a subsequent review of complaint cases establish a lack of willingness to accept civilian oversight, a move to a completely civilian-run complaints investigation system would have to be entertained.

4. *Alone and Cold* – Report of the Davies Commission’s Inquiry into the Death of Frank Paul

In early December of 1998, Frank Paul died in a Vancouver alley after being dropped off in that location by city police officers. After a lengthy delay, Judge William Davies conducted an inquiry into the circumstances surrounding the death of Frank Paul and the subsequent investigation into police actions related to his death (Davies, 2008). Commissioner Davies made a number of wide-ranging recommendations for reform as a consequence of his findings during the inquiry.

The Davies Commission recommended that the police get out of the business of arresting and detaining intoxicated persons. He looked at programs in existence elsewhere that offer alternatives to the practice of the police arresting individuals for being intoxicated in public, and holding them in cells (often referred to as a “drunk tank”) until they are sufficiently sober to merit release back into the community. The report recommended that Vancouver adopt a civilian-operated “sober-

ing centre,” and that various reforms be put in place such as providing adequate detoxification programming and providing viable housing alternatives for homeless alcoholics and managed alcohol programming (p. 197).

Commissioner Davies also looked into the way in which police-involved deaths are investigated. The process of investigating police-involved deaths in Vancouver at the time of the Frank Paul incident used the Vancouver Police Department’s own Major Crime Section to carry out the investigation. The procedure did not involve any control or oversight of the investigation by any outside source. Upon completion of the investigation, a report was forwarded to Crown Counsel without any recommendations regarding whether any charges should be laid, and if so, what those charges should be. The problem with the police and prosecutorial process in such cases, as identified by Commissioner Davies, was the issue of “divided loyalties.”

As a consequence of his concern regarding the Vancouver Police Department’s policy of self-investigation, Commissioner Davies determined that “nothing short of a wholesale restructuring” of these investigations would be capable of addressing the matter (p. 210). He noted that “the public is entitled to expect that those conducting investigations of police-related deaths act with undivided loyalty to the public interest, to the exclusion of all personal or collegial interests” (p. 210). Where a police officer belongs to the same department as the officer being investigated, the potential for the investigating officer to be influenced so as to perform his or her investigation in a less than unbiased manner is omnipresent. In the words of Commissioner Davies, “one cannot fault the public for being distrustful of the process, especially if no criminal charges result” (p. 211).

Commissioner Davies concluded that a home police department should never conduct crimi-

nal investigations of police-involved deaths (p. 234). He went on to conclude that the conflict of interest present in police investigating themselves could only be resolved by moving to the use of an independent civilian agency to conduct investigations of police-involved deaths (p. 241).

5. *Police Investigating Police - Final Report of the Commission for Public Complaints Against the RCMP*

In 2007, Paul Kennedy, the Chair of the Commission for Public Complaints Against the RCMP at the time, initiated an inquiry into public concerns regarding the impartiality of RCMP members investigating other RCMP members in cases involving serious injury or death. This resulted in the publication of a report in which he made numerous recommendations for change in the way investigations of allegations of serious wrongdoing by RCMP members are carried out (Kennedy, 2009). While the report was not specifically about police-involved deaths, it did focus on the way in which investigations of police-involved deaths should be carried out.

This inquiry looked at a sample of cases involving allegations of serious wrongdoing by RCMP members. Until recently, the investigation of any allegations of wrongdoing by RCMP officers involved an investigation carried out by other RCMP officers, regardless of whether the officer in question was fulfilling a federal policing function, or a contracted municipal or provincial policing function. Kennedy's report addressed the process employed to investigate alleged wrongdoing and provided recommendations for reform.

In reviewing the sample of cases, Mr. Kennedy found serious cause for concern with more than two-thirds of the cases being handled inappropriately. In a quarter of the cases in the sample, the investigator personally knew the officer under investigation. In one-third of the cases, the investigator was of an equal or lower rank

than the officer under investigation. Additionally, in 60 percent of the cases, there was only one officer conducting the investigation (p. 69).

In his recommendations for reform, Mr. Kennedy fell short of recommending genuine independent civilian investigation. It appears the cost associated with a move to this model led him to adopt a significantly more modest set of proposals. Instead of civilian investigation, Mr. Kennedy recommended that other police agencies, or an external provincial investigation body where one is available, be used to conduct the investigation of cases of police-involved deaths and some other serious cases. The RCMP accepted these recommendations in early 2010 (RCMP, 2010).

6. *Restoring Public Confidence: Restricting the Use of Conducted Energy Weapons in British Columbia - the Braidwood Inquiry Report (Part 1)*

In 2008, retired appeal court justice Tom Braidwood was appointed to conduct a commission of inquiry into the death of Robert Dziekanski following an incident at the Vancouver International Airport in which he was tasered by members of the RCMP. The commission's work was divided into two phases, one looking at the police use of conducted energy weapons, and a second looking into the circumstances of Mr. Dziekanski's death. Commissioner Braidwood released a report on the first part of his inquiry in mid-2009 (Braidwood, 2009).

The Braidwood report criticized the B.C. provincial government for abdicating its responsibility to set province-wide standards on the use of tasers. He went on to recommend that police use more caution in deploying tasers, restricting their use to circumstances in which a suspect threatens bodily harm, rather than the prevailing standard which allowed their use if a suspect was actively resistant. He also recommended that

repeated use of the stun guns on a subject in a single encounter be avoided in all but the rarest cases, noting the increased medical risks associated with repeated deployment of the devices.

It is notable that Mr. Braidwood fell short of calling for a moratorium on the use of tasers, claiming that such an approach would result in the loss of the positive benefits the devices can provide in appropriate circumstances.

While the recent B.C. Solicitor General, Kash Heed, asserted the recommendations would be adopted wholesale throughout the province (British Columbia, 2009), the RCMP noted that it would “review and assess” the findings before definitively altering existing policy, which it claimed was already in substantial compliance with Commissioner Braidwood’s recommendations (RCMP 2009). The manufacturer of Taser also followed up the report by seeking judicial review of Mr. Braidwood’s report, claiming it was a result of bias among commission staff (CBC News, 2009a). In early 2010, the RCMP announced new Taser rules, restricting their use to circumstances in which a person is “causing bodily harm” or an officer believes on reasonable grounds that a person is “imminently” going to harm someone (CBC News, 2010).

7. Oversight Unseen – the Ontario Ombudsman’s Report on the SIU

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

The report compliments Ontario for moving to the forefront of the civilian investigation move-

ment by being the first Canadian jurisdiction to use a genuine civilian-led and civilian staffed investigative agency. However, numerous problems were identified. Public perception of the SIU was that it had the image of being a “toothless tiger and muzzled watchdog” (Marin, 2008: 74).

The independence of the agency was called into question, particularly due to continuing police links brought about by former police officials being employed as investigators in the unit. In some instances, police refused to cooperate with SIU investigators. Delays in being notified of cases requiring SIU involvement were compounded by delays in getting to incident scenes and further delays in interviewing witnesses. Decisions made by the SIU not to charge police officers are not subject to explanation in a public venue, causing further concern. A significant concern was the deference given to the police by SIU investigators during their investigations. There was a reluctance to insist on police cooperation. The internal culture of the SIU was found to have been adversely affected by the large number of ex-police officers on staff.

The report concludes with a list of 45 recommendations for reform, including aggressively pursuing reasons for non-cooperation. The report notes that active steps should also be taken to minimize delay, and the SIU should seek to diversify its staff, and distance itself from connections to the police. Changes to legislation were also recommended in order to enhance the mandate and legislative authority of the SIU.

8. Why? The Robert Dziekanski Tragedy – the Braidwood Inquiry Report (Part 2)

In June of 2010, retired justice Braidwood released the second part of his report on the Taser related death of Robert Dziekanski. The second part of the report focussed on the circumstances surrounding the tragic death, as a supplement to the first part of the report which concentrated on Taser use by the police. The report

identified how the policies in place and the conduct of those involved in the tragic death could have been altered so as to prevent the outcome.

An important part of the final report is found in a postscript devoted to the issue of the police investigating themselves. In that portion of the report, Mr. Braidwood called for the adoption of the recommendation of Mr. Davies recommendations in the Frank Paul Inquiry report to create a civilian investigative agency to replace the practice of the police investigating themselves in serious incident cases. Mr. Braidwood went on to call for an expansion of the Davies reforms in a number of areas.

Mr. Braidwood called for the creation of a civilian Independent Investigation Office. That office should be led by a civilian director and be composed of non-police investigators who have no prior police experience. The Agency should have the mandate to investigate all police-involved deaths and incidents causing serious harm, plus incidents involving alleged *Criminal Code* violations by police, as well as other offences that might undermine public confidence in the police. He made specific recommendations regarding the breadth of the powers the investigators should have, and he called for the use of special prosecutors to do charge approval and to conduct the prosecution of the police who are charged.

iii. Human Rights Organizations

1. Amnesty International

The principal focus of Amnesty International's (AI) concern over police-related deaths in Canada has centred on police use of conducted energy weapons. This concern led to the issuance of several reports and public statements in recent years (Amnesty International, 2004, 2007a, 2007b).

In 2007, Amnesty issued a report entitled: *Canada: Inappropriate and Excessive Use of Tasers* (Amnesty International, 2007a). That report

documented instances of taser use on children, taser use to awaken sleeping men, taser use in other situations where there was no serious risk of harm to the officers or others present at the scene, and numerous incidents where individuals had died following police deployment of tasers. AI recommended suspending all use of electric shock devices pending an independent and impartial inquiry into the use and effects of these weapons. The report also called for police to comply with international standards regarding use of force, to provide appropriate use of force training to police, and to ensure all allegations of human rights violations are fully and impartially investigated. The report also made recommendations for those police agencies unwilling to give up electric shock weapons that would significantly curtail the deployment of these devices. In addition, the report called for further restrictions on the use of force by the police against individuals believed to suffer from mental illness. Amnesty International has claimed that at least 271 taser-related deaths occurred at the hands of law enforcement in the US between 2001 and 2007 (Amnesty International, 2007c).

Later in 2007, after the death of Robert Dziekanski, Amnesty International issued a public statement again calling for the suspension of the use of tasers by Canadian police (Amnesty International, 2007b).

Prior to Taser reports, Amnesty International's major concern about police-involved deaths was in regard to the 1995 police shooting death of Dudley George, an aboriginal man killed during a land claims dispute in Ontario. Amnesty called for a public inquiry into the matter (Amnesty International, 2003). This incident was finally the subject of a commission of inquiry which released its report more than ten years after the incident (Linden, 2007). That report criticised the provincial government and the police handling of the incident.

2. Liberty

In England, concern over the process of investigation into police complaints, particularly into allegations of serious wrongdoing by the police, led to the civil liberties organization, Liberty, preparing a report on the matter (Harrison & Cunneen, 2000). That report resulted in recommendations to create a genuinely independent body to investigate complaints against the police. Those recommendations were taken to heart by Britain's Parliament, resulting in the passage of the *Police Reform Act 2002*,⁶ and the consequent creation of the Independent Police Complaints Commission for England in 2004. That body, while funded by the UK Home Office, operates as a body completely independent from the police, interest groups, political parties, and at arm's length from the government.

3. American Civil Liberties Union

In 1997, the American Civil Liberties Union (ACLU) recommended reform to police accountability throughout the US through the adoption of "civilian review" (American Civil Liberties Union, 1997). The ACLU noted that civilian review comes in various guises; however, the need to increase police accountability to outside sources was an obvious area of needed reform. The ACLU note that by 1997, over 75 percent of the largest cities in the US had some form of civilian review in place. The push for civilian control of the investigation of allegations of police wrongdoing and for civilian accountability were presented as part of an overall reform agenda seeking to minimize police misconduct.

The ACLU identified a number of stages that communities typically go through when the prospect of civilian review, including civilian investigation of police wrongdoing is contemplated. They note that police opposition is to be expected as a jurisdiction seeks to adopt change in this area. This typically follows three stages:

- The "over our dead bodies" stage, during which the police proclaim that they will never accept any type of civilian oversight under any circumstances;
- The "magical conversion" stage, when it becomes politically inevitable that civilian review will be adopted. At this point, former police opponents suddenly become civilian review experts and propose the weakest possible models;
- The "post-partum resistance" stage, when the newly established civilian review board must fight police opposition to its budget, authority, access to information, etc. (ACLU, 1997).

The ACLU note that strong advocacy in the community is necessary to overcome resistance by the police – resistance that persists even after the new regime is put in place. The report goes on to note the varieties of civilian review processes that may present themselves, and the relative merits of a genuine civilian system, with civilian investigators, is outlined.

ii. Academic Studies

A number of academic studies have touched on deaths in custody. A few have even looked at issues arising in Canada; however, there has not been a comprehensive academic analysis of the wide range of issues arising in relation to police-involved deaths.

Many of the academic studies on deaths in custody have been published in medical journals, concentrating on causes of death and the goal of prevention. A major study on deaths in custody (looking at provincial jail custody and federal penitentiary custody as well as police custody) was published by Wobeser and her colleagues (2002). This research looked at coroner's files on 308 inmate deaths between 1990

and 1999 in Ontario. Of this total, 58 died in police cells. Among this latter group, the majority died from strangulation-related suicide ($n = 26$) and from toxicity ($n = 21$), while a smaller number died from natural ($n = 6$) and other causes ($n = 5$). The research found police-involved deaths had a greater tendency to be violent in nature (including toxicity and suicide) when compared to deaths in the prison context. The research also noted that the overall rate of death among incarcerated individuals is higher than the rate of death in the general population.

Some of the medical-related literature has concentrated on drug and alcohol-related deaths in custody. Research by Karch and Stephens (1999) noted the high incidence of stimulant-related abuse (often cocaine) that results in death during the arrest and transportation of suspects. They also noted that drug toxicity from ingested drugs consumed by drug dealers and smugglers is the principal form of drug-related death among detainees during the first 12 hours of their detention. Drug-related deaths occurring after 12 hours were typically found to arise from intoxicant withdrawal or other natural causes. Research conducted by Giles and Sandrin (1992) concentrated on alcohol-related police-involved deaths. They also looked at the Ontario coroner's data, in their cases from the 1980s. While dated, their findings draw attention to the ongoing phenomenon of deaths from alcohol toxicity while in police custody. They found that 80% of those dying in custody had alcohol in their system at the time of death. Of all those who died in police custody over the study period, 61% had been arrested and brought into custody for public drunkenness. Acute intoxication-related toxicity and suicide while in an intoxicated state were identified in their discussion as major areas of concern. The authors noted the positive impact on reducing suicide-deaths associated with video surveillance which started to become popular near the end of their study period. They also made calls for reform,

including enhanced medical and psychiatric evaluation at the time of intake, and the need for enhanced police officer education on identifying and dealing with alcohol-related toxicity.

Similar research conducted in the UK by Norfolk (1998) looked at deaths in 1994 in that jurisdiction. He found that police detention of inebriated individuals was an inappropriate approach to this social problem. He asserted that alternatives should be explored, taking the detention of intoxicated arrestees out of the hands of the police.

A historical review of deaths in custody in the state of Maryland has revealed that patterns have changed over time (Grant et al., 2007). This research amalgamated files pertaining to police lock-ups with those involving county, state and federal custodial institutions in the US. From the 1930s to the 1970s natural causes such as cardiovascular disease were the most prevalent causes of death in custody. In the 1980s suicidal asphyxia became the most common cause. Drug intoxication deaths first appeared in the records in the 1980s and became more common in the 1990s and 2000s. A limitation of this study is that it did not differentiate between police custody and other forms of custody. It is also unclear whether the same trends have prevailed in Canada.

Numerous other jurisdiction-specific studies have looked at police-involved deaths, revealing similar findings to those prevailing in Canada. For example, Heide and colleagues (2009) found a need for increased medical attention for those in police custody in Germany. Deaths arising from alcohol or drug intoxication present a persistent problem in that jurisdiction as well as ours.

Research conducted in Maryland, USA (Southall et al., 2008) revealed a large proportion of in-custody deaths involved African-American men. They found a significant role was played by alcohol and drug intoxication, but

also that nearly half of the victims suffered from natural diseases such as heart disease.

Recent research in the UK noted the potential benefits of referring arrestees intoxicated by alcohol to a custody suite in which brief intervention in the form of education and treatment for the detainee is available. This may present a better response than simple detention and release (Hopkins and Sparrow, 2006).

One American study pointed to the potential value of relying on coroners as a source of data on in-custody deaths (Pelfrey and Covington, 2007). Since in-custody deaths are typically the subject of a coroner's inquest, they noted that coroner's data presents an excellent source of information.

Coroner's Data

Determining the number of police-involved deaths and the circumstances under which they occur should be tasks that are relatively easy to complete by accessing coroners' and medical examiners' data. The responsible office in each province maintains a record of the numbers of deaths in police custody.⁷ Additionally, they are a source of rich data regarding the individual incidents. While identifying the numbers of deaths in custody is usually readily ascertainable, finding out more detailed information is another matter entirely.

Legislation exists across the country that requires all police-involved deaths be subjected to an investigation into the circumstance surrounding the death.⁸ Each of the Canadian provinces and territories has its own legislation and coroner's courts, as well as its own system of death investigation. Some jurisdictions have a coroner system,⁹ while some have a medical examiner system.¹⁰ Each jurisdiction operates in slightly different ways from one another.

For example, in British Columbia, Part 2 of the *Coroners Act* provides in section 3(2):

s. 3 ...(2) A peace officer must immediately report to a coroner the facts and circumstances relating to the death of a person who dies

- (a) while detained by or in the custody, or in a custodial facility, of a peace officer, or
- (b) as a result, directly or indirectly, of an act of a peace officer performed in the course of his or her duty.

Upon receipt of such a report, an investigation must be conducted into the circumstances surrounding the death:

s. 7 A coroner must conduct an investigation if the coroner

- (a) receives a report of a death that occurred in British Columbia, and
- (b) is satisfied that the matters reported, if true, suggest that the death was required to be reported under Part 2.

Furthermore, until recently, an inquest had to be conducted in British Columbia whenever a death occurred in police custody:

s. 18 (1) A coroner must hold an inquest if directed to do so

- (a) under this Division, by the chief coroner, or
- (b) under section 19, by the minister.

(2) The chief coroner must direct a coroner to hold an inquest if the deceased person died in any of the circumstances

es described in section 3 (2) (a) [*deaths while in the custody of peace officers*].

In 2010, this was changed when the second part of s. 18 was replaced with the following:

s. 18 ... (2) If a deceased person died in a circumstance described in section 3 (2)(a) [*death while in custody of peace officer*], the chief coroner must direct a coroner to hold an inquest unless any of the following apply, in which case the chief coroner may direct a coroner to hold an inquest:

- (a) the chief coroner is satisfied that
 - (i) the deceased person's death was due to natural causes and was not preventable, or
 - (ii) there was no meaningful connection between the deceased person's death and the nature of the care or supervision received by the person while detained or in custody;

(b) the circumstances of the deceased person's death are or will be the subject of a commission of inquiry established under the *Public Inquiry Act* or under section 2 of the *Inquiries Act* (Canada).

(2.1) If the chief coroner decides under subsection (2) of this section that an inquest is not required, the chief coroner must

- (a) report the decision to the minister and include with the report
 - (i) the authority on which the decision is based, and

(ii) the reasons for the decision,

(b) subject to subsection (2.2), make the report public, and

(c) direct a coroner to make a report in accordance with section 16 (1) (a) respecting the deceased person's death.

(2.2) Section 69 (2) [*disclosure to the public or interested persons*] applies for the purposes of a report made under subsection (2.1) (b).

(2.3) The chief coroner may reconsider a decision under subsection (2) that an inquest is not required and direct an inquest to be held if any of the following circumstances apply:

(a) in the case of a decision based on a reason set out in subsection (2) (a), if new evidence has arisen or has been discovered that

(i) is substantial and material to the deceased person's death, and

(ii) did not exist at the time of the investigation of the deceased person's death, or did exist at that time but was not discovered and could not have been discovered through the exercise of due diligence;

(b) in any case, if the chief coroner considers it would be in the public interest.

(3) The chief coroner may direct a coroner to hold an inquest if the chief coroner has reason to believe that

- (a) the public has an interest in being informed of the circumstances surrounding the death, or
 - (b) the death resulted from a dangerous practice or circumstance, and similar deaths could be prevented if recommendations were made to the public or an authority.
- (4) The chief coroner may direct a coroner to hold a single inquest in respect of more than one death if the chief coroner
- (a) directs a coroner to hold an inquest under this Division, and
 - (b) has reason to believe that the facts or circumstances relating to more than one death are sufficiently similar that separate inquests are not necessary.

Taking away the mandatory nature of a coroner's inquest in police custody deaths is a major cause for concern. Requiring an inquest ensured the public that every death in custody would be given the serious attention it deserves. Rather than enhancing police accountability, this reform erodes accountability, leading to a concern that police-involved deaths are not treated as seriously as the families of the deceased individuals would like. This change takes police-involved deaths further out of the public spotlight than has been the case up until now.

Coroners and medical examiners do not routinely publish or publically disseminate details of in-custody deaths.¹¹ Only Ontario provided detailed information regarding police-involved deaths. A review of the data provided by each contributing province provides some insight; however, fairly rich data can be mined from the Ontario files. The following is a summary of the major findings from each province and a more detailed look at the Ontario data.

Coroner Data from Various Provinces/Territories

A detailed examination of all available files of Coroners' inquests into deaths of people who died in custody between 1992 and 2006 was done for four provinces and two territories. The province of B.C. and the Yukon Territory included data for the 2007 year which was also used. Data collected included age, cause of death, location of death, history of alcohol and/or drug abuse, and ethnicity (when given). The results for each province are outlined below. For our purposes, deaths in custody included solely deaths that occurred in police cells, and not that occurred in federal penitentiaries and provincial prisons. Deaths that occur in police custody account for a significant proportion of custodial deaths in Canada, some of which are preventable. Focusing exclusively on these deaths allows us to understand custody-related police operations and procedures.

1. British Columbia

Between 1992 and 2007, there were 267 people who died in police custody in the province of B.C. The majority of these deaths were of men (n=243), with women accounting for only 9 percent of all deaths (n=24). The information regarding deaths in custody for B.C. was provided as aggregate data, with the following categories: age (given as a range), gender, manner of death, location/circumstances involving death, and city (jurisdiction). A category for ethnicity was not included. Women were not considered separately; instead, information on women was combined with that of men for most purposes. The information provided did not provide any detail on the circumstances surrounding the deaths, nor did it provide case histories for any individuals who died in police custody. Since only aggregate data was provided, only the most basic information about in-custody deaths in B.C. is available.

The data indicates an overall decline in the number of police-involved deaths in B.C. between 1992 and 2007 (see Table 1). In 1992, there were 24 people who died in police custody (23 men, 1 woman), the second highest number recorded in this province. The data shows a general decline thereafter in the number of deaths per year, but another peak occurred in 2004, with 27 people (24 men, 3 women) who died in police-custody, an all-time high for this province. There was a significant decrease in 2007, with 11 people dying (10 men, 1 woman), the second lowest number for deaths in custody for this province.

As previously mentioned, the majority of deaths in custody that occurred between 1992 and 2007 were of men (n=243), accounting for 91% of all deaths. In comparison, there was a relatively small number of women who died in custody (n=24). The substantial difference between the number of men and the number of women who died in custody is a common trend that is seen in different jurisdictions and countries throughout the globe. Based on the data, a gender-specific analysis was not possible but future considerations call for further inquiry into understanding the differences between male and female deaths in custody. A gender-specific analysis of deaths in custody in Australia found some interesting differences prevail along gender lines (Collins & Mouzou, 2022).

Over a 15 year period, the B.C. data indicates a fluctuation in the number of deaths in custody for men, while the number of deaths in custody for women has remained relatively stable (see Table 2). The number of deaths for men increased from 3 in 1995 to 24 in 2004. This significant increase, over almost a decade, is indeed quite troubling. In contrast, the number of deaths for women remained relatively low, ranging from 0-4. From 2000 to 2006, the number of deaths for women appeared to be increasing with a peak in 2006 with 4 deaths, but dropping to 1 death the following year.

The most common manner of death for people who died in police custody between 1992 and 2007 in B.C. was categorized as accidental (n=141), accounting for 53 percent of all deaths (see Table 3). The data on manner of death includes both men and women, as a breakdown of the manner of death by gender is not available. The coroner’s data does not offer case histories of any individual who died in police custody, so we have no details surrounding the deaths. As a result, we are unaware of the extent of any alcohol/substance abuse, mental illness, or health problems that may have existed, and could have potentially contributed to death. Suicides were the second most common manner of death (n=41), constituting 15 percent of all deaths in custody. Homicides (n=38) accounted

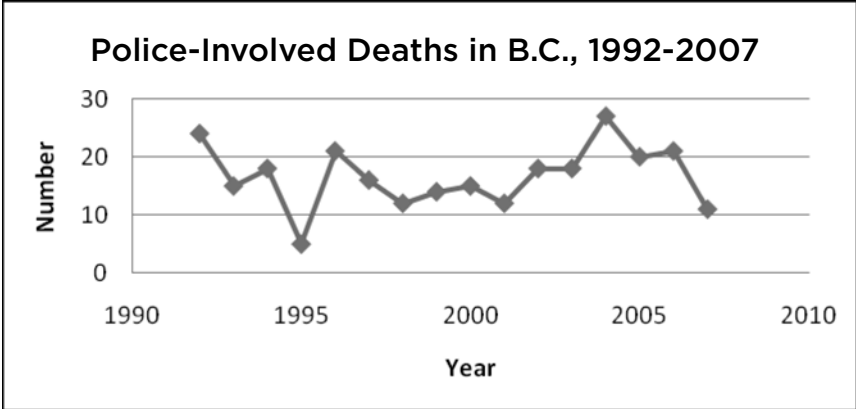


Table 1: Police-involved deaths in B.C., 1992-2007

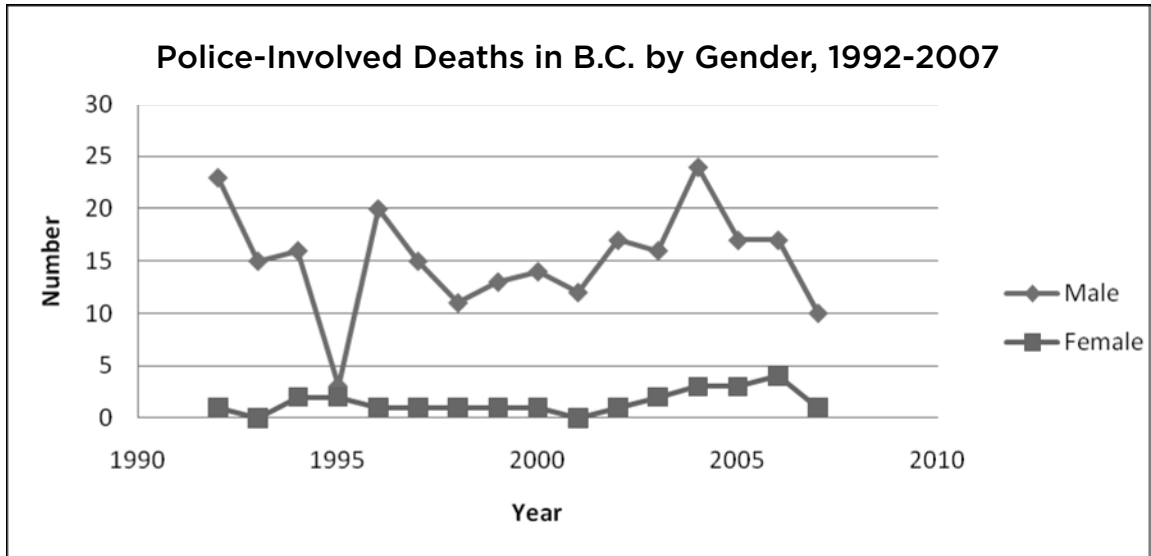


Table 2: Police-involved deaths in B.C. by gender, 1992-2007

Manner of Death																	
	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	Total
Accident	8	5	7	5	14	14	6	7	9	5	13	11	10	12	11	4	141
Homicide	9	2	2	0	2	0	0	3	3	0	1	3	7	3	1	2	38
Natural	2	0	4	0	0	0	3	0	2	4	2	1	5	0	0	0	23
Suicide	4	6	4	0	4	2	1	3	1	2	1	2	5	3	3	0	41
Undetermined	1	2	1	0	1	0	2	1	0	1	1	1	0	2	6	5	24
Total	24	15	18	5	21	16	12	14	15	12	18	18	27	20	21	11	267

Table 3: Deaths in-custody in B.C., 1992-2007

for 14 percent of all deaths and deaths that occurred due to natural causes (n=23) accounted for 8.6 percent. Deaths that were classified as “undetermined” (n=24) constituted 8.9 percent of all deaths in custody. According to the data, the total for “undetermined” deaths was larger than the total of “natural” deaths. B.C. was the only province where this was the case. The category for “undetermined” deaths should always be the smallest category, consisting of the least number of deaths. Categorizing a death as “undetermined” should only occur in the rarest of cases. Unfortunately, without a reading of the case histories, we are unaware of the circumstances surrounding the deaths in custody.

In B.C., deaths in custody were most common in the 30-39 (n=81) age group, accounting for 30.3 percent of all deaths (see Table 4). The 40-49 (n=56) and 20-29 (n=52) age groups were very similar in numbers, accounting for 20.9 percent and 19.4 percent respectively. Combined, these three age groups (20-49) account for 70.7 percent (n=189) of people who died in police custody between 1992 and 2007. One would think that those in the 20-49 age group would, theoretically, be the group that is among the most likely to consist of healthy people with minimal health problems, yet this age group had the highest number of deaths in custody. This trend is difficult to explain when

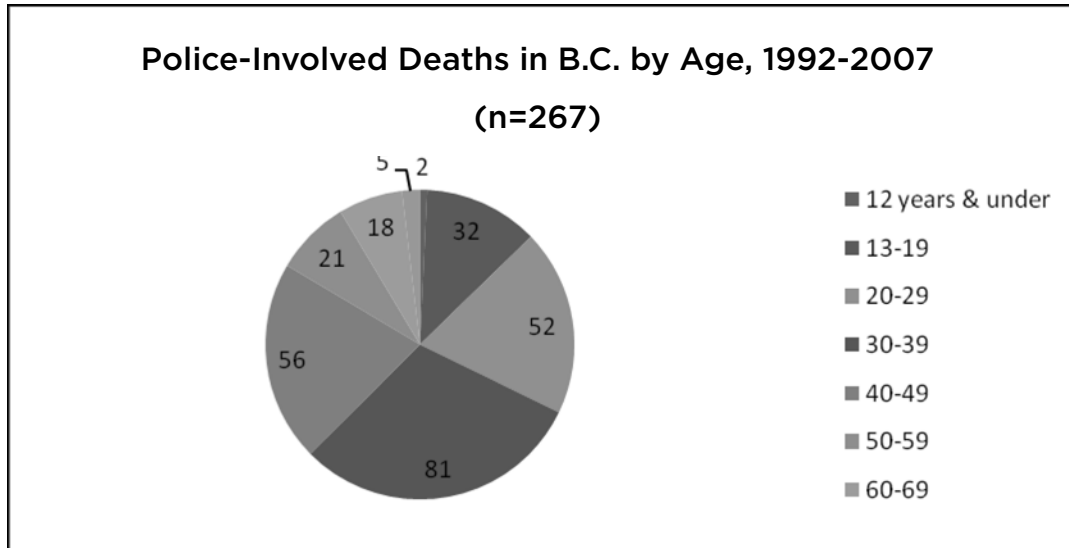


Table 4: Police-involved deaths in B.C. by age, 1992-2007

the circumstances surrounding the deaths are unknown. Only 16.4 percent of people who died in police custody were between the ages of 50-79 (n=44), an age group likely to make up the category for “natural causes” for the manner of death. However, this statistic is low in comparison to other age groups. That is, there are fewer people dying in custody due to natural causes, and more as a result of other causes. The remaining age group consisted of people 19 and younger (n=34), which accounted for 12.7 percent of all police-involved deaths.

Table 5 (see below) indicates 4 possible categories under which the deaths occurred in B.C. Thirty-six percent (n=96) of deaths in custody involved the police in some manner but no specifics were given. Regarding location of death, 28.9 percent (n=77) of the deaths in custody occurred in police cells/police lockup, 22 percent (n=59) of deaths occurred during an auto pursuit involving police, and 13.1 percent (n=35) of deaths involved a police shooting.

Circumstances of death		
	Number	Percentage
Police Custody - Cell/Lockup	77	28.9%
Police: Shooting	35	13.1%
Police: Auto Pursuit Involved	59	22.0%
Police: Other	96	36%
Provincial Total	267	100%

Table 5: Police-involved deaths in B.C., 1992-2007

Manner of Death				
	Police Custody: Cell-Lockup	Police-Provincial Jail/Detention Centre	Police Chase	Total
1992/1993	1	0	2	3
1993/1994	0	1	0	1
1994/1995	0	1	0	1
1995/1996	0	0	0	0
1996/1997	0	0	0	0
1997/1998	1	0	0	1
1998/1999	0	1	1	2
1999/2000	0	0	0	0
2000/2001	0	1	3	4
2001/2002	1	1	0	2
2002/2003	0	0	0	0
2003/2004	3	1	0	4
2004/2005	0	2	0	2
2005	0	0	0	0
2006	1	2	0	3
Total	7	10	6	23

Table 6: Deaths in-custody/police-/involved deaths

2. New Brunswick

Between 1992/93 and 2006, there were 23 people who died in police custody in the province of New Brunswick (see Table 6). The data from the office of the chief coroner was based on aggregate data, with no detail given on the circumstances surrounding the deaths. The data included a category for the number of people who died in a federal institution, which for our purposes was excluded. Additional categories included age, gender and classification of death, but again the data did not distinguish between the custodial deaths, and included those who died in a federal institution, and as a result, could not be used. The reporting period changed to calendar year in 2005 but does not repeat statistical data reported in 2004/2005.

According to the data, 43% of all deaths occurred in police provincial jail/detention centre

(n=10), with a peak in the number of deaths (n=2) occurring in 2004/2005 and another peak in 2006 (n=2). 30% (n=7) of deaths occurred in police cells, with a peak (n=3) in 2003/2004. The last category we were able to use data from indicates 26 percent (n=6) of deaths involved a police chase, with a peak (n=3) in 2000/2001.

3. Northwest Territories

A total of 8 people (7 men, 1 woman) died in police custody between the years 1995 and 2002 in the Northwest Territories. Data for the 3 years prior to 1995 was not available. The coroner's information for police-involved deaths in this jurisdiction was very limited, failing at times to offer even the most basic information. Of all the available data from the provinces and territorial jurisdictions, the Northwest Territories had the least number of deaths in custody, not a sur-

prise due to the sparse population in the north. Again, no detail was given for the circumstances surrounding the deaths. The majority of deaths (75 percent (n=6)) were classified as suicides, and the remaining 25 percent (n=2) were classified as accidental. The location of all deaths in this province occurred in one of three places: RCMP cells (n=3), a halfway house (n=1), and a corrections centre (n=2). The deaths of the remaining two men occurred after the detainees had escaped from their cells, but both of these deaths were classified by the coroner as “suicides”. Without any detailed information it is hard to surmise what in fact happened in these two cases. Based on the coroner’s report, the two men escaped from their cells and committed suicide. While it is hard to believe that a person would escape from their cell to commit suicide, there was no indication in the coroner’s information of a possible altercation that may have transpired with police, nor was there any indication of police force or weapons that were used. Age was given for those who died in police custody, with a mean age of 30 years.

4. Nova Scotia

The province of Nova Scotia only started collecting information on deaths in custody/police-involved deaths on a database in 2007. Prior to that, all record keeping was paper generated. As a result, the data from this province was not provided.

5. Saskatchewan

A total of 16 people died in police custody (13 men, 3 women) between the years 2000 and 2006 in Saskatchewan. Data was not available prior to 2000. The coroner’s information indicated that of the 16 people who died in police custody, 35 percent (n=6) were Aboriginal. The data for this province had missing data information for some of the individuals including no age for 12 of the men, no cause of death identified for 5 of the men, and no

location of death for 6 of the men. The ages of only 4 of the deceased (3 women, 1 man) were included in the data. Of these four, the mean age was 27.5. Only 69 percent (n=11) of the deaths were classified by the coroner. Of these, 27 percent (n=3) were classified as accidents and another 27 percent (n=3) were the result of natural causes. Eighteen percent of the deaths were suicides (n=2) and another 18 percent (n=2) were ruled as homicides. In both homicide cases, the deceased were shot by the police where weapons and force were used. There was 1 death that was classified as undetermined. The coroner’s notes indicated that in this case the deceased was a known drug addict.

6. Yukon

The data provided by the coroner included police-involved and correctional facility deaths from 1992 to 2007 in the Yukon Territory. There were a total of 11 cases, with a significant proportion (n=8) accounting for police-involved deaths. Case histories and details surrounding the circumstances of death were provided for all individuals. The majority of people who died in police custody were men (n=6), with a relatively small number of women (n=2). The ethnicity for all those who died in police custody was recorded in the data for the Yukon. Six of the eight deaths were of First Nations peoples, with the other 2 being a Caucasian man and a Caucasian woman. It is important to note that Statistics Canada reports from the 2006 census that 25.1 percent of the Yukon’s population is First Nations, a relatively significant proportion, whereas nationwide the proportion decreases to 3.8 percent.

The majority of the deaths were ruled as accidental (n=4). In all four cases, drugs and/or alcohol played a significant role. Of the remaining cases, two were ruled as suicides, one as a homicide, and one as natural death. None of the deaths were ruled as “undetermined.”

The majority of the deaths (n=4) occurred in police cells. In three cases, the deceased were men; in one, a woman. Three of the four (two men, one woman) were arrested for public intoxication, and the other man for causing a disturbance. There were two deaths that occurred as a result of an auto pursuit involving police, one occurring in a police vehicle en route to the courthouse, and one at the deceased's home.

The data indicates a fluctuation of the number of deaths in custody between 1992 and 2007. According to the data, the first police-involved death occurred in 1995 in the Yukon, with none occurring in the following two years. From 1998-2000, there was an increase in the number of police-related deaths, with a total of five such incidents. There were no deaths in custody after 2000 until 2003, when there were another two police-related deaths.

Below, are detailed case histories of the eight individuals who died in police custody in Yukon between 1992 and 2007, and the circumstances surrounding their deaths:

March 30, 1995 - A 40 year-old Caucasian man died at Whitehorse General Hospital. He was arrested for public intoxication and logged into police cells at 5:35 pm. At 11:10 pm, the man was discovered not breathing. CPR was administered and the ambulance transported the man to the hospital where he was pronounced dead. The deceased had a history of drug/alcohol abuse and idiopathic seizures. No use of force or weapons was used. The death was ruled an accident as a result of acute morphine overdose with significant contributing factor being acute alcohol intoxication.

September 9, 1998 - A 23 year-old First Nations man died at Vancouver General Hospital where he had been medevaced from Whitehorse, Yukon. Two days earlier, an RCMP officer received a call regarding a stolen car along with a description and license number. The of-

ficer eventually observed the car and pursued it. The suspect lost control of the vehicle and a foot chase ensued. The officer caught up with the suspect and there was an altercation between the two men. The suspect was able to put the officer in a chokehold. Fearing for his life, the officer shot the suspect. A police issued weapon was used. The suspect did not have a weapon. The death was ruled a homicide with the cause of death being a gunshot wound to the head.

March 11, 1999 - A 44 year-old First Nations man died in his home after RCMP arrived there. The deceased had a physical altercation with his common-law wife who went to a neighbour's home and called the RCMP. They surrounded the house and phone contact was made. An RCMP negotiator was also called in. The RCMP were unaware the deceased had a gun. Around noon, a gunshot was heard. The RCMP entered the home and found the deceased with a gunshot wound to the head and a gun in his left hand. The death was ruled a suicide with the cause of death as a gunshot wound to the head.

December 25, 1999 - A 38 year-old First Nations man was pronounced dead at Whitehorse General Hospital. The deceased had been picked up by the RCMP for causing a disturbance and housed in cells. He was brought to the hospital by ambulance from RCMP cells where he was found hanging from a strip from a blanket. The death was ruled a suicide by hanging.

March 18, 2000 - A 36 year-old First Nations man was pronounced dead at the Watson Lake General Hospital. The man had been housed in RCMP cells for public intoxication. He was taken to hospital by ambulance after he was discovered collapsed in his cell. The death was ruled an accident from acute alcohol poisoning.

June 14, 2000 - A First Nations woman died at Whitehorse General Hospital. On May 31, the woman had been taken to RCMP cells for public intoxication. She was found having dif-

ficulty breathing and was taken by ambulance to hospital. She was medevaced to hospital in Vancouver and returned to Whitehorse Hospital on June 09, where she remained on life support until she died. The death was ruled as natural due to multifocal bilateral pneumonia, the consequences of anoxic ischemia encephalopathy as a result of cardio-respiratory arrest.

September 27, 2003 - A 37 year-old Caucasian woman died at Km. 132 on the South Klondike Highway, Yukon, while being transported in an RCMP vehicle. The deceased was being transported from Carcross to Whitehorse to attend court on charges of cultivating marijuana. The police vehicle left the road and the deceased was thrown from the vehicle. She was not wearing a seatbelt. The death was ruled an accident due to multiple injuries as a result of a motor vehicle accident.

September 28, 2003 - A 34 year-old First Nations man was pronounced dead at Whitehorse General Hospital. The deceased had been involved in an RCMP police chase near Lewes

Lake, Yukon when the officer noticed the man was not wearing a seatbelt. He was seen to ingest a white substance and became medically distressed. RCMP performed CPR and he was taken to hospital by ambulance. The death was ruled an accident due to acute cocaine intoxication.

7. Ontario: A Detailed Picture

A total of 113 people died in police custody in Ontario between 1992 and 2006. Within this group, 103 were men, and only 10 were women. The number of deaths fluctuated over the years, ranging from a low of 2 in 2006 to a high of 12 in 1992. This data shows a slight declining trend over the 14 year period. However, the numbers fluctuated up and down over the review period rather than declining steadily (see Figure 1).

The average age of the males who died in custody was 38.6 years, and for females it was 33.1 years. About half of them (n = 55) died in police cells (see Table 7). Clearly, addressing the number of deaths in police cells is an important matter for those concerned with police-involved deaths (Krames & Flett,

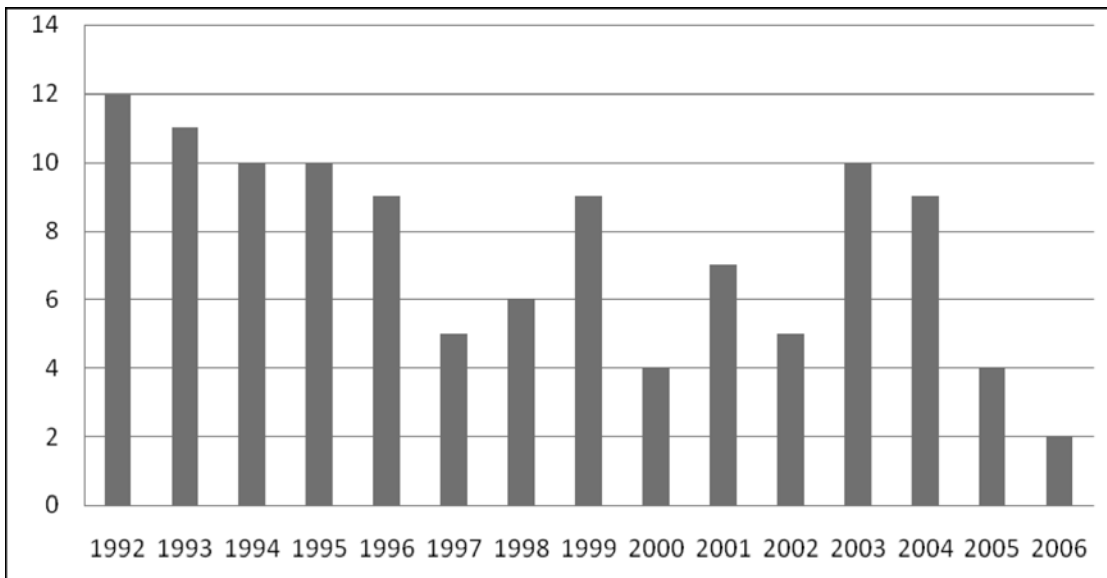


Figure 1: Number of deaths in Ontario police custody by year

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

Table 7: Location of death

2005; Norfolk, 1998). However, since half of the deaths in custody occur outside holding cells, the development of policy in this area must take this into account, accommodating the various locations in which deaths occur.

Some detainees die at the scene of their initial encounter with the police, while others die at a police station or after being taken to a hospital for medical attention. In this sample, eight died in their own home. In addition, one individual died in a homeless shelter, one person died in an apartment lobby, another died in an airport, two others in a washroom, and one in their own backyard. Some detainees became ill or injured and passed away en route to a hospital or after their arrival at that location. In this sample,

five died in an ambulance en route to a hospital, while another eleven died in a hospital. Two detainees died in a police car, while eight people died in a police station, but not in police cells.

People died in police custody from a number of causes. Coroners typically classify the cause of death as falling into one of five categories: homicide, suicide, accident, natural, and where the cause is unclear, undetermined. The cases of those dying in Ontario police custody broke down as outlined in Table 8.

During the study period, almost half of those dying in police custody died from an accidental cause (52 of 113). Over a quarter of the subjects ($n = 33$) committed suicide. Of the remainder, 18

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

Table 8: Cause of death

were found to have died from natural causes and a few were categorized as a victim of homicide (n = 4) or given an undetermined ruling (n = 6).

Alcohol and drug consumption play important roles in the circumstances leading to many in-custody deaths. The “accidental” death category includes the largest and most diverse group of circumstances leading to in-custody deaths. Almost two-thirds of this group (n = 32) died from drug or alcohol poisoning. If individuals categorized as dying from “excited delirium” induced by cocaine ingestion (n = 6) are included, almost three quarters of the accidental deaths can be directly linked to excessive drug or alcohol consumption (see Table 9).

Of the 38 individuals (34% of the total sample) who died as a direct result of drug and/or alcohol ingestion, 12 were found to have died

as a result of alcohol poisoning, 21 as a result of drug overdose, and 5 from the combined effects of drugs and alcohol. The number of individuals dying in police cells who had consumed excessive amounts of alcohol is a major concern for those interested in police custody deaths, discussed in more detail below.

It is to be expected that some individuals brought into police custody will pass away from natural causes. However, the stress associated with being brought into police custody undoubtedly has an impact on the numbers dying under such circumstances. Although only 18 of the 113 subjects in this study were identified as dying of natural causes, almost three quarters of these (n = 13) died from heart failure. Many of these individuals were found to have had coronary artery or heart disease, which was undoubtedly exacerbated by the stress of arrest

Manner of Accidental Death	Number	Percentage
Drug/alcohol overdose	32	61
Excited delirium (w/ cocaine)	6	11
Positional asphyxia	3	6
Respiratory distress syndrome	1	2
Drowned during escape	1	2
Hit by car during escape	1	2
Drowned during escape	1	2
Car crash	1	2
Hanging	1	2
Brain injury	1	2
Undetermined/unclear	5	10
Total	52	100

Table 9: Accidents - manner of death

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

Table 10: Suicides - manner of death

and booking. Of the remainder, one died from liver cirrhosis, one from a brain aneurysm, two from a seizure disorder and one was identified as dying from an undetermined cause.

Thirty-three individuals in this study died as a result of committing suicide. The clear majority of these individuals (n = 25) died from ligature strangulation, typically as a result of hanging themselves in a police cell (see Table 10). A further five individuals overdosed on drugs, two stabbed themselves to death, and one individual jumped to their death.

On release of the original print version of this report, the Royal Canadian Mounted Police in British Columbia (“RCMP”) set out to get greater certainty around the Ontario police-involved death statistics. Working with the Ontario Coroner’s office, they were able to obtain the following tables in two weeks, tables that through months of FOI requests the B.C. Civil Liberties Association was unable to access.

The RCMP vouches for the accuracy of these numbers and the BCCLA has accepted them

as accurate and as comprehensive as we can hope to obtain. We reproduce them here in the electronic version for the reader’s reference. We note that these statistics do not invalidate the Ontario tables contained earlier in this section, but are more comprehensive categories of statistics that include the report’s original numbers.

While comparisons are difficult, we note that when roughly comparing B.C.’s statistics of 267 police-involved deaths to Ontario’s 316 deaths, on a per capita basis (Ontario population 4.531m; B.C. population 13.2107m according to Statistics Canada as of November 10, 2010), B.C.’s rate of police-involved deaths is one for every 16,970 people, and Ontario’s rate is one for every 41,806 people.

In other words, B.C.’s police-involved death rate appears to be 2.5 times higher than Ontario’s. The BCCLA continues to urge provincial governments and police departments to collect and share these data with the public to ensure problematic trends can be identified and lives can be saved.

Tables 11-14 are from the Office of the Chief Coroner, Province of Ontario and show all custody deaths from 1992 to 2007.

Custody – Provincial Jail/Detention Centre						
Year	Natural	Accident	Suicide	Homicide	Undetermined	Total
1992	6	5	2	0	3	16
1993	5	0	4	0	0	9
1994	3	0	5	0	0	8
1995	7	0	2	1	0	10
1996	9	0	5	1	1	16
1997	5	2	1	0	0	8
1998	3	1	2	0	2	8
1999	5	3	1	0	0	9
2000	5	1	4	2	0	12
2001	2	2	0	0	0	4
2002	6	3	3	0	2	14
2003	6	3	4	2	0	15
2004	5	3	1	1	1	11
2005	5	1	3	0	0	9
2006	9	3	6	0	3	21
2007	11	3	3	0	1	18
Total						188
Table 11						

Custody – Police Cell, Lockup						
Year	Natural	Accident	Suicide	Homicide	Undetermined	Total
1992	1	3	1	0	0	5
1993	0	1	4	0	0	5
1994	1	1	3	0	1	6
1995	2	4	2	0	0	8
1996	2	6	4	0	0	12
1997	1	2	1	0	1	5
1998	1	0	7	1	2	11
1999	2	1	4	0	0	7
2000	1	0	4	0	1	6
2001	2	1	3	0	1	7
2002	5	0	1	0	0	6
2003	2	2	0	0	1	5
2004	2	2	5	1	0	10
2005	3	1	2	0	0	6
2006	1	2	0	0	0	3
2007	1	3	1	0	0	5
Total						107
Table 12						

Custody – Federal Institution						
Year	Natural	Accident	Suicide	Homicide	Undeter- mined	Total
1992	3	0	4	4	0	11
1993	6	2	5	3	2	18
1994	3	3	0	2	1	9
1995	10	1	4	2	1	18
1996	13	2	5	1	0	21
1997	8	2	7	1	0	18
1998	12	5	4	1	0	22
1999	13	0	4	4	1	22
2000	7	4	4	0	1	15
2001	13	2	4	1	0	20
2002	7	0	1	0	1	9
2003	8	3	4	2	0	17
2004	6	0	1	0	0	7
2005	10	2	3	0	0	15
2006	7	0	3	0	0	10
2007	11	2	1	0	1	15
Total						248
Table 13						

Custody/Detention – Under arrest, not in jail						
Year	Natural	Accident	Suicide	Homicide	Undeter- mined	Total
1992	0	1	0	0	0	1
1993	2	0	0	0	0	2
1994	0	2	0	0	0	2
1995	1	2	0	0	0	3
1996	0	0	1	0	0	1
1997	0	0	1	0	0	1
1998	1	2	0	0	0	3
1999	2	1	1	0	0	4
2000	1	0	4	0	1	6
2001	2	0	0	0	0	2
2002	1	0	0	0	0	1
2003	1	1	1	0	0	3
2004	0	1	0	0	0	1
2005	1	1	0	0	2	4
2006	3	2	1	0	1	7
2007	3	2	0	0	0	5
Total						46
Table 14						

Chapter 3

Alternative Models of Investigation

a. How Investigations are Carried Out: Police Investigating Police

The search for a fair and effective process to deal with public complaints about the police has been one of the most “elusive goals of modern policing” (Smith, 2005, p. 121). In most of Canada, allegations of police misconduct are investigated by other police officers. Typically, minor allegations of wrongdoing are investigated by those working in the agency’s own professional standards unit, while more serious acts of wrongdoing are investigated by serious crime investigators from the same agency employing the officer being investigated. In British Columbia, policing is carried out by municipal police agencies¹² and by the RCMP.¹³ Beginning this year, deaths and other very serious allegations of wrongdoing involving municipal police agencies, primarily located in many urban areas of the Lower Mainland and Greater Victoria, are investigated by police officers from a police agency other than the one implicated in the circumstances.¹⁴ Deaths and serious injuries involving the RCMP are almost always investigated by other RCMP officers.¹⁵

In Ontario, police-involved deaths are investigated by the Special Investigations Unit (SIU). This is a civilian agency responsible for investigating all serious allegations of police wrongdoing discussed in more detail elsewhere in this chapter. Over the past several years, various jurisdictions in Canada have begun to move towards using an external, non-police agency to carry out investigations of allegations of deaths and serious injuries arising at the hands of the police. This reflects developments that have arisen in other democratic

societies, where external, civilian investigation of police wrongdoing has become the norm.

b. Legal and Policy Frameworks

In Canada, jurisdiction over policing is accepted as being split among all three levels of government: federal, provincial and municipal. A single federal police force, the Royal Canadian Mounted Police, operates across Canada. Its role is fairly limited, concentrating on the enforcement of certain federal statutes such as those pertaining to drugs and certain aspects of commercial crime. Provinces are generally responsible for providing policing services within their territory, and both Quebec and Ontario have established police forces for this purpose. Outside these two provinces, the rest of the provinces in Canada have entered contracts with the federal government to use the RCMP as a provincial police force. In British Columbia, a provincial police force existed until the 1950s; however, since abandoning its own force, B.C. has contracted the RCMP to fulfil provincial policing responsibilities. Most provinces require municipalities to provide their own policing services once they reach a sufficiently large size to merit this expense. For example, once a municipality in B.C. reaches a population of 5,000 it is required to provide its own police force.¹⁶ Municipalities may either establish their own police agency, or they may contract with the province for it to provide policing services. In Ontario, this resulted in many small communities contracting to use the Ontario Provincial Police (OPP) as a municipal police force. In provinces like B.C., where

the RCMP is contracted to do policing for the province, the municipality will ultimately be contracting for the RCMP to do its policing if it does not establish its own police agency.

Because of the split in jurisdiction and the use of the RCMP as a contracted police force, the legal framework governing policing in Canada is fairly complicated. The RCMP is governed by the RCMP Act,¹⁷ a federal statute applicable to all aspects of the RCMP, including aspects of the organization that pertain to contract policing. Each province also has its own policing legislation. This legislation typically applies to both the municipal and provincial police within a given jurisdiction. In provinces such as B.C. where there is no provincial police force (i.e. where the RCMP is contracted to deliver policing for the province), the legislation will be primarily directed towards those police agencies that are genuinely local in nature, the municipal police forces created by various municipalities in the province.

Due to the application of a legal doctrine known as “inter-jurisdictional immunity”, the provincial legislation does not directly affect the discipline of members of the RCMP delivering policing services under contract,¹⁸ nor does it allow the province to exercise control over the administration and management of the RCMP operating under contract.¹⁹ These aspects of the RCMP are subject to the overriding control set out in the *RCMP Act*.

i. Coroner’s Services: Police Investigating Police?

In most jurisdictions, and until recently in British Columbia, all police involved deaths are the subject of a coroner/medical examiner investigation. This appears to be a mechanism of genuine external oversight devoid of the taint of police investigating the police. However, this may be less of a genuine safeguard than it first appears.

From 2001 until 2010, in British Columbia, the Chief Coroner has been a former RCMP officer, Terry Smith. Other Chief Coroner’s in this province have been former police officers as well, such as Larry Campbell (1996-2001), and his predecessors Vincent Cain and Robert Galbraith.²⁰ While the coroners working in the B.C. Coroners Service come from many backgrounds, it is notable that several coroners working under the Chief Coroner include former police officers.

ii. Agencies for the Investigation of Alleged Police Wrongdoing

While the police have historically investigated allegations of wrongdoing themselves, in recent decades, we have seen a move towards external investigation of alleged police wrongdoing. Variations on the theme of external investigation exist. These may be placed on a continuum ranging from marginal independence to complete independence by a non-police agency. On this continuum, police may be investigated by an internal affairs/professional standards unit or a major crime section within the same agency. Police may be investigated by the same agency, but with investigative oversight by officers from a neighbouring agency. Police may be investigated by a neighbouring police agency. Police may be investigated by a neighbouring police agency, but with civilian oversight or control. Police may be investigated by a separate investigative agency composed of seconded officers. Police may be investigated by a separate civilian-led agency using both seconded and civilian investigators (who are typically former police officers). Police may be investigated by a genuine civilian-led and civilian staffed investigative agency with no ties to the police agency being investigated.

1. Examples of the Models as Applied in Other Jurisdictions

Over the past 20 years, the need for an effective system for dealing with complaints against the

Internal	Quasi-internal	Hybrid-Quasi-Internal	Hybrid	Hybrid-Quasi-External	Quasi-External	External
Police investigated by officers from within the same agency	Police investigated by the same agency with investigative oversight by officers from another police agency	Police investigated by police from a nearby police agency	Police investigated by police from a nearby police agency under civilian oversight and/or control	Police investigated by a civilian-led agency using seconded police	Police investigated by a civilian agency using seconded and civilian investigators	Police investigated by a civilian agency that is led and staffed by non-police civilians
Table 1: Agencies for the investigation of alleged police wrongdoing						

police has been a legitimate concern in British Columbia and other jurisdictions around the globe. A number of high profile death in-custody cases have brought the issue of whether it is necessary and appropriate to allow police to investigate themselves to the forefront of public attention. The call for reform has grown out of the inherent dangers in allowing the police to investigate themselves, where the prospect of any objectivity, legitimacy, or truth is questionable. This dubious practice has led to grave public mistrust of the police and a complete lack of faith in the entire complaints system.

In an attempt to restore public confidence in the complaints process as a whole, various models have been employed in different jurisdictions around the world. These systems do not conform to a single model, with varying degrees of external involvement and oversight. In theory, every complaints process is intended to provide an effective, independent and impartial system. However in practice, this is not the case. A major criticism of some of these newly adopted oversight systems is their lack of independence from the police. Many jurisdictions continue to use seconded and/or former and/or retired police to conduct investigations of alleged police wrongdoing, based on the argument that this practice ensures the most professional standards

of investigation and the minimization of any perception of bias so long as serving officers are not being used. In actuality, this practice still results in police investigating police. Once an individual enters the police profession they adopt a change of identity that they may carry with them for the rest of their life (Vincent, 1990). Indoctrination into the police culture has cumulative effects; these effects tend to be more pronounced on those who have been in the organization for long periods of time. Employing retired or long-term police officers as investigators has obvious pitfalls. Although police have been investigating themselves in many jurisdictions for many years, alternatives to this practice need to be fully explored.

Over the past ten years, and in particular over the last five years, the image and reputation of the police has been tarnished. Trying to regain public trust and confidence in the police is not an easy task, but allowing the police to investigate themselves has undoubtedly had a more adverse effect than the police can imagine. The trust of the public can only be preserved if the police complaints process is handled and investigated by an independent third party. This requires a civilian led agency, where not only is there civilian oversight but more importantly, there is a civilian-managed and civilian-run process.

Jurisdictions in other countries and some Canadian provinces have mandated independent organizations to investigate complaints against the police. An examination and evaluation of current practices and models employed in England and Wales, Northern Ireland, South Australia, and various provinces in Canada are provided below.

a. England and Wales: The Independent Police Complaints Commission

In England and Wales, a new model was adopted to deal with complaints against the police with the establishment of the Independent Police Complaints Commission (IPCC), which became operational on April 1, 2004. Prior to the advent of the IPCC, the Police Complaints Authority (PCA) handled any complaints and allegations of misconduct against the police in England and Wales. In 1985, the PCA replaced the Police Complaints Board and it remained in existence until 2004. The IPCC brought increased independence over prior systems of accountability, moving away from the police investigating themselves, which was the hallmark of those prior systems (Maguire, 1991).

The IPCC is a non-departmental government body, funded by the Home Office. The organization consists of a chair and commissioners, all of whom are appointed for a five year term by the Queen and Home Secretary respectively. Operationally, the IPCC is run by a chief executive and a team of directors. Nick Hardwick was appointed as the first Chair of the IPCC in December 2002. Prior to his appointment, Hardwick was Chief Executive of the Refugee Council from 1995 to 2003 - the largest refugee agency in Europe. He was Chair of the European Council on Refugees and Exiles from 1999 to 2003. Jane Furniss became the IPCC's Chief Executive on December 4, 2006. She is an independent member of the Legal Complaints Service and a trustee of the non-profit groups Crisis and National Institute for Crime Preven-

tion and Reintegration of Offenders (NICRO). "By law, no member of the commission may have served as a police officer" (IPCC website). As a result of this legislative mandate, the IPCC is independent of the police. The statutory powers and responsibilities of the IPCC are set out in the Police Reform Act 2002.²¹

In addition to having jurisdiction over the police in England and Wales, since 2006, the IPCC's authority extends to handling complaints against the staff of the Serious Organized Crime Agency (SOCA) and Her Majesty's Revenue and Customs (HMRC). As of February 2008, the IPCC's authority extended even further to cover the investigation of matters involving officers and officials of the UK Border Agency (UKBA). The police forces in England and Wales, HMRC, SOCA and UKBA have a statutory duty to report any incident of serious injury or death to the IPCC.

The IPCC's role is to ensure that complaints against the police are handled effectively and efficiently by increasing public confidence through demonstrating the independence, accountability, and integrity of the entire complaints system.²² The functions of the IPCC include assisting in "supervising" and "managing" some internal police investigations, with the IPCC only conducting independent investigations into serious incidents or allegations of misconduct by police officers. Serious incidents are those involving death or serious injury. Serious allegations also involve the following: allegations of serious or organized corruption, offences committed by senior officers, racism, or perverting the course of justice.²³

The IPCC can exercise any of the following three options available to them when dealing with complaints: (1) investigation by the police "supervised" by the IPCC (i.e. investigation supervised by the IPCC but conducted under direction and control of either the police, HMRC,

SOCA or UKBA); (2) investigation by the police “managed” by the IPCC (i.e. conducted by the police, HMRC, SOCA, or UKBA but under direction and supervision of IPCC); and (3) investigation by the IPCC (i.e. conducted by the IPCC). While the first procedure existed and was employed under the old system, the latter two procedures were developed under the new model. “Managed” and “supervised” are similar procedures; however, “managed” investigations allow for more day-to-day direction and control of the officers appointed to investigate by the IPCC (Seneviratne, 2004). Independent investigation is a new process which gives the IPCC the ability to train and employ their own investigators in order to conduct a completely independent investigation of complaints (Seneviratne, 2004). These investigators have the same powers of seizure and questioning as the police, allowing them to thoroughly conduct an independent investigation (Seneviratne, 2004).

The police are compelled to cooperate with the IPCC’s investigations. This includes providing access to documents and any other relevant materials. The IPCC also has access to all police premises.

For complaints that are handled within the police force, the above-mentioned powers given to the IPCC are still available even when the IPCC is merely overseeing the investigation.

After the IPCC has conducted an investigation, they are able to make recommendations and give directions on any disciplinary actions that need to be taken. They are also responsible for directing the disclosure of specific information and directing the re-investigation of an incident. If the IPCC directs a police force to bring disciplinary charges, it can present cases against police officers at misconduct hearings.

The police are primarily responsible for recording complaints, although this can be regulated by the IPCC (Seneviratne, 2004). The police

held similar powers under the old Police Complaints Authority system (PCA) in England and Wales. However, a major difference between the two systems is that under the new system, if the police refuse to record a complaint, reasons for this decision must be given to the IPCC (Seneviratne, 2004). Furthermore, the complainant has the right of appeal to the IPCC if the complaint was not initially recorded. All complaints involving death or serious injury must be recorded and referred to the IPCC.

Complaints can be resolved informally by police through a process known as “local resolution”. However, local resolution procedures are monitored by the IPCC. This can be done with the complainant’s written consent, and where the conduct, if proved, would not justify criminal or disciplinary proceedings.

Evaluation of IPCC

Prior to the establishment of the IPCC, the old system in England and Wales, the Police Complaints Authority (PCA), was criticised primarily for their lack of independence. The new system however, does not appear to be all that different from its predecessor. While no member of the commission by law may have served as a police officer, two of the three options available to the IPCC for dealing with complaints still involves using police to investigate, with the IPCC only conducting independent investigations into serious incidents or allegations of misconduct by persons serving with the police. In these cases, the IPCC use their own investigators, who possess the relevant skill set necessary to conduct investigations but do not have any police training. IPCC Commissioner Nicholas Long admitted that “the expertise required need not be obtained solely from experience as a police officer” (Kennedy, 2009).

Given that the IPCC employs and trains their own investigators, they are equipped with staff capable of conducting independent investiga-

tions. While independent investigations may be time consuming, we should be more concerned with getting the job done “right” as opposed to getting the job done “quickly”. In addition, the IPCC should eliminate their “supervising” and “managing” functions, and instead assume the responsibility of investigating *all* complaints of police wrongdoing/misconduct, thus maintaining independence and impartiality.

The IPCC model has been criticised for the ongoing role of the police in carrying out the bulk of investigations. In regard to the continued use of police to investigate police, the independence of such as process has been critiqued as “illusory and ineffective” (Cunneen and Harrison, 2001, p. 8), as unlikely to satisfy its “most ardent critics” (Ormerod and Roberts, 2003, p. 147), and as a process that “does not appear to be so sufficiently different from its predecessor to be convincing as a wholly independent system” (Seneviratne, 2004, p. 336). According to Smith, “the police have managed to retain control of the complaints process as a consequence of the under-representation of complainants’ interests throughout the recent history of reform” (Smith, 2005, p. 123). Unless the process is modified to increase its independence from police influence and control, the IPCC model must be considered an insufficient model to guide genuine reform.

b. Police Ombudsman for Northern Ireland

In Northern Ireland, a new system was developed ten years ago to investigate complaints against the police based on an Ombudsman model. The Office of the Police Ombudsman for Northern Ireland (PONI) is a non-departmental public body that is intended to provide an independent, impartial police complaints system. This new model was established under the *Police Act (Northern Ireland) 1998* and became active in 2000.²⁴ The role of the office of the PONI is to ensure that complaints against the

police are handled effectively and efficiently by maintaining independence and increasing the confidence of the public and members of the police in the complaints system.

The PONI is responsible for investigating complaints involving the conduct of police, including all allegations of criminal misconduct. The PONI must investigate all cases of death or serious injury, but has the power to investigate all complaints against the police. The PONI is not responsible for matters pertaining to the direction and control of police. The Police Ombudsman is appointed by Her Majesty, as a named person for a fixed term of seven years (Kennedy, 2009). The Police Ombudsman is accountable to Parliament, through the Secretary of State.

The Office of the Police Ombudsman is comprised of approximately 150 staff, who come from police and non-police backgrounds alike. While none of the staff from the Police Ombudsman’s Office are active members of the Police Service of Northern Ireland (PSNI), some of the staff do come from policing backgrounds and are retired or former police officers. In addition, the PONI does have several police officers seconded from police services other than the PSNI who are used to assist in the conduct of investigations. The annual budget for the PONI is around \$18 million; however, it handles more than 3,000 complaints per year.

Nuala O’Loan was the first Police Ombudsman in Northern Ireland (PONI), serving between the years 1999 and 2007. She is a qualified solicitor and was a law lecturer at the University of Ulster until her appointment as Ombudsman. In July 2009, Baroness O’Loan was appointed to the House of Lords and was subsequently replaced as PONI by former oversight commissioner Al Hutchinson, who officially became the second Ombudsman for Northern Ireland on November 6, 2007. Prior to this, Hutchinson served 34 years with the Royal Canadian

Mounted Police (RCMP), eventually becoming Assistant Commissioner. The Police Ombudsman is supported by the Chief Executive, Samuel Pollock (whose prior service included 20 years in probation and prison services), and a senior management team composed of six directors. It is worth noting that both the Senior Director of Investigations, Jim Coupland, and the Director of Investigations, John Larkin are retired police officers. Hutchison believes that by building “a mix of seconded and retired police officers as well as civilians, you will build a body that is competent, professional, fair and accountable” (Kennedy, 2009, p. 21).

All complaints pertaining to police misconduct in Northern Ireland are handled by the Office of the Police Ombudsman. The Police Ombudsman has the power to decide how a complaint should be handled. The PONI can investigate, informally resolve, or seek mediation of a complaint. The latter two procedures can be used in cases of minor complaints. Informal resolution is conducted by the police themselves and requires the complainant’s consent. However, the PONI must agree that all elements of the complaint have been addressed to the satisfaction of all parties involved.

The PONI employs their own investigating team to conduct investigations, with wide-ranging powers. The police have a duty to co-operate with the PONI’s investigation and are obligated to provide access to any material and documentation. Failure to cooperate with the PONI’s investigation is considered a criminal offence. Similar to the IPCC model, the PONI is able to make recommendations which can include compensation, and it may give directions on any disciplinary actions if an investigation reveals a criminal act may have occurred. However, if criminal activity is established, this must be referred to the Director of Public Prosecutions for Northern Ireland.

Evaluation of PONI

The PONI system is often referred to as the “civilian control model”. In fact, the first Ombudsman considered the model to be “the most advanced model of police oversight in the world” (O’Loan, 2000). Initially, the major strength of this model was that it actually represented a completely independent system of investigation. The PONI’s office was responsible for collecting evidence, visiting the crime scene and conducting investigations using their own staff. Even in cases that are resolved informally by police, the PONI maintains control over the process. The Office of the Police Ombudsman appears to have been given sufficient resources and proper funding which allows it to carry out its duties and functions effectively.

While O’Loan received a lot of praise for her vigorous investigation of alleged police wrongdoing, this praise was equally met with criticism, particularly from officers working for the Police Service of Northern Ireland (PSNI) who felt the office was not an impartial body, being biased against the police. Following extensive criticism, O’Loan was not reappointed for a second term. It appears she was not reappointed because of her relentless criticism of the PSNI and its officers. The Ombudsman system was in fact ideal with a civilian director such as it was under O’Loan, but in 2007 with the appointment of a new Police Ombudsman, the pendulum swung in a different direction. This once civilian-led agency is now headed by a former RCMP Assistant Commissioner, displaying a return to a system dominated by police-thinking with a former senior police officer at the head. This questionable appointment has brought us back to the very root of the problem; that is, police investigating police. How can the public trust the findings of the Police Ombudsman (a former RCMP Assistant Commissioner), his team of directors (which

includes two former police officers), and the investigative staff, which is made up of other former police officers, and even seconded serving police officers, as impartial and unbiased? With this new leadership, the PONI has arguably become a less than ideal model of police oversight rather than retaining its previous status as possibly the best in the world. It is noteworthy that PONI, like many other police oversight systems, not only uses former police officers for their “investigative expertise,” but the current Police Ombudsman is himself a former police officer. This flaw arises at the very top of the chain of command, and is bound to have a trickle down effect through the whole organization, leaving the results of investigations carried out by this organization appearing tainted and unreliable in the eyes of the public.

Despite these criticisms, the PONI system is still quite highly regarded in police accountability circles. It is genuinely independent, and it appears to be perceived in this way (Seneviratne, 2004). In 2007-2008, the PONI charges 19 police officers with criminal offences, most of which were assaults (Mason, 2008, p. 3). It has been noted that the “most striking aspect of the system for dealing with complaints against the police in Northern Ireland is that the process is completely independent of the police” (Seneviratne, 2004, p. 340). It is also a positive aspect of the PONI system that they handle the full range of investigations, including allegations of minor wrongdoing as well as the most serious incidents.

c. South Australia Police Complaints Authority

Most of the above-mentioned oversight bodies were created in response to grave public mistrust and a lack of faith in police investigations and accountability structures in the UK. In other commonwealth jurisdictions, reform efforts have led to significant changes

in some jurisdictions, but not in others.²⁵ For example, the South Australian Police Complaints Authority (PCA) was prompted by a wave of Australian states beginning to establish oversight agencies in the 1980s, with a general consensus appearing to prevail that such a system was desirable (Police Complaint Authority website). South Australia was the last of the Australian states to adopt a reformed system of police oversight. Prior to the establishment of the PCA, all complaints were investigated internally and the police force made its own assessment on how to proceed with a complaint.

The office of the PCA was established pursuant to the 1985 Act of the South Australian legislature.²⁶ It is an independent statutory body, which directly answers to Parliament. It is also independent of the South Australian Police (SAPOL), with no member of its staff being an active police officer. In accordance with the 1985 Act, the head of the PCA must be a barrister, solicitor or legal practitioner of the High Court or Supreme Court (Kennedy, 2009). The current head of the PCA, who took up office on December 10, 2009, was previously the Anti-Discrimination Commissioner in Tasmania. The former PCA was a legal practitioner who, prior to being appointed in 1995, had 25 years of legal experience. The first PCA was an Industrial Magistrate, and the second was a prosecutor who had been working with the Western Australian Ombudsman. The staff of the Authority includes lawyers, a conciliation officer, an investigator, and administrative support.

The system established under the Act follows a model of “external monitoring of internal investigation”, rather than developing a completely independent investigative body (PCA website). The Act delegated the responsibility of primary investigations of complaints to the Internal Investigative Branch (IIB) of the South Australian Police (a team of experi-

enced police officers), subject to the oversight of the PCA. In exceptional circumstances, the PCA may conduct primary investigations of complaints. This includes complaints about senior police officers, members of the Internal Investigative Branch (IIB), complaints made about public servants employed by the South Australian Police, and complaints pertaining to policies, procedures, or practices of the police force. There is also a provision which allows the PCA to conduct an investigation where the Authority considers there are reasons for doing so.

In any of the above-mentioned circumstances, the PCA will launch their own investigation using “experienced officers” from an independent area. The PCA has one full-time investigator who is a former police officer with substantial experience in the following areas: general duties, major crash investigation and road traffic enforcement (Kennedy, 2009). This PCA investigator is allowed to investigate his former unit. However, he cannot investigate anyone with whom he has worked closely or anyone with whom he has maintained a personal relationship. In these cases, to avoid a conflict of interest, the PCA Chair can investigate the case himself, or he can delegate the investigation to be undertaken by one of the lawyers on his staff. However, the expectation is that the “majority of investigations will be conducted by the Internal Investigate Branch” (PCA website). This has been the norm since the Act was introduced. While the PCA determines how investigations will be handled, this decision is made in consultation with the officer in charge of the IIB.

Complaints can be made by any person either directly to the PCA or to any member of the police force, excluding the officer who is the subject of the complaint. In either case, the complaint must be registered by the PCA and the complainant notified of subsequent developments. Complaints can also be made on behalf of another person and complaints should be made in writing whenever possible.

There are a couple of different options available to the PCA for resolving complaints depending on the seriousness of the incident. The process of conciliation can be used to deal with complaints against police officers that are less serious in nature. Allegations suitable for conciliation are deemed to be those that, even if proved, would not ordinarily justify a criminal or disciplinary charge (e.g. the use of bad language). A complaint can only be dealt with through conciliation if the complainant has consented to the procedure. Complainants may withdraw their consent at any time during this process.

The process of conciliation begins with the complainant giving details of the complaint either to a member of the police force or an officer with the PCA and a desired outcome from the informal resolution. The police officer who is the subject of the complaint will be spoken to by either their supervisor or the resolving officer and given an opportunity to respond to the complaint. The whole process of conciliation is normally completed within 14 days.

The more complicated or serious cases require a full investigation. Again, these investigations are generally conducted by the IIB. The investigator is responsible for speaking to the complainant, officer(s) involved, and any other persons who may be involved or who can help with the investigation. It is important to note that the PCA will monitor the progress of all investigations and may inspect any documents or speak to any persons involving a complaint.

After completing an investigation, and once the Commissioner of Police is satisfied with the investigation, a copy of the report is sent to the PCA. After assessing the investigation report, the PCA may ask for further investigation to be carried out, if necessary, or the PCA can make recommendations to the Commissioner of Police on how to remedy the problem if an investigation reveals police misconduct or wrongdoing. The PCA can

make recommendations to the Commissioner regarding the following: whether a police officer(s) should be charged with an offence or breach of discipline; whether a decision should be reconsidered or reasons should be given for a decision; whether a law, policy or procedure should be changed; or whether no action should be taken (Kennedy, 2009). If the PCA recommends disciplinary charges, these are heard by a magistrate sitting as the Police Disciplinary Tribunal and the penalty is assessed by the Commissioner of Police or the Deputy Commissioner (Kennedy, 2009). In the event that the PCA and Commissioner of Police cannot agree on the results of an investigation or the necessary and appropriate action required to be taken, the case will be forwarded to the responsible Minister for resolution.

Evaluation of the PCA

The structure of the system of police oversight established in South Australia is disappointingly similar to many others. The essence of the concern is that this system encourages the continued involvement of police at all stages of the complaints process. The PCA maintains that this gives the system consistency in dealing with all complaints against the police in a like manner to allegations of wrongdoing committed by members of the public. According to the former PCA chairman (Anthony Wainwright) “police are very much part of the solution to any problems they may have” (Kennedy, 2009, p. 227). His term ended December 10, 2009.

The 1985 Act, under which the PCA was created, seems to be the root of the problem with this system. The Act gave the SAPOL’s IIB the responsibility of conducting primary investigations, anticipating that the majority of investigations will be carried out by IIB officers. As a result of this questionable policy, the PCA’s role is to “externally monitor”, only conducting its own investigations in exceptional cases defined under the Act. It is very important to note that

death or serious injury are not even listed as exceptional cases, but could arguably fall under the category “other exceptional circumstances”.

Overall, the PCA’s power and role are fairly limited. The bulk of the power seems to be in the hands of the IIB who are in charge of conducting the majority of investigations. Even when the PCA conducts primary investigations itself, the current lead investigator was previously a police officer for 18 years. In addition, he is allowed to investigate the police department that formerly employed him, giving rise to a perception of bias and a perceived conflict of interest. Regardless of how complaints are resolved, whether through a full-fledged investigation of a complaint or the use of conciliation and informal resolution for a less serious incident, the police force is involved every step of the way. South Australia’s entire complaints process is centered on the use of police. This model represents yet another oversight system where police are used to investigate police.²⁷

2. Canadian Models

a. Ontario: Special Investigations Unit

Ontario was the first Canadian province to develop and implement an independent oversight body to handle investigations of police wrongdoing with the creation of the Special Investigations Unit (SIU) in 1990. This independent, civilian-led agency is responsible for conducting criminal investigations involving serious injury or death or allegations of sexual assault committed by police.²⁸ The SIU has full power and authority to investigate, and where the evidence warrants, may charge officers with a criminal offence (SIU Website). However, in the majority of cases, there is no evidence of criminal activity and no charges are laid. It is worth noting that the SIU’s primary role is to conduct an independent, thorough, and impartial investigation, assuring the public that the conduct of police is not excused and is subject to careful examination. It is not necessarily the SIU’s role

to lay charges. The SIU's powers, responsibilities and duties are set out in the *Police Services Act*.

Section 113 of the *Police Services Act* addresses the duty of members of police forces to cooperate with SIU investigations. However, this has been a source of contention for the SIU since the onset. There have been issues with the police failing to fully co-operate with the SIU (Scott, 2009). This was one of the major concerns with the operation of the SIU identified in a recent report on the organization by the province's Ombudsman (Marin, 2008).

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

The SIU consists of a Director, who is appointed by Cabinet, as well as civilian investigators, who are appointed under the *Public Service Act*. The SIU is led by the current Director Ian Scott, a lawyer who has practised exclusively in the areas of criminal and administrative law. With an annual budget of around \$7 million, the SIU employs a total of 80 people including 40 full-time staff, 14 full-time investigators (7 with a policing background and 7 non-po-

lice investigators), and 40 as-needed officers, mainly consisting of retired police officers (Scott, 2009). The investigative staff includes individuals who are experts in traffic accident investigations and collision reconstruction (SIU Website). The SIU also has its own in-house Forensic Identification Section, with the ability to carry out all forensic identification work without relying on police crime scene technicians. This team is led by two full-time forensic identification supervisors, and ten "as-needed" forensic identification technicians.

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

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

SIU's investigation of police occurrences have increased every year since the SIU was created in 1990, and have doubled since the early 2000s (Scott, 2009). For the 2009 year, Scott noted there had been a 15% increase in the number of cases addressed by the SIU compared to the previous year. In-custody cases are the most common occurrences that are investigated. Out of 257 occurrences that were investigated up to September in 2009, there were 9 charges laid against 11 officers (Scott, 2009).

Evaluation of SIU

Prior to the establishment of the SIU, cases resulting in serious injury or death involving police in Ontario were investigated by police. That system represents the traditional model of investigating police wrongdoing, without oversight. In that previous system the police were totally autonomous, handling criminal investigations of their own officers internally. However, in 1990, with the advent of the SIU, a radical change occurred. The reform offered by the SIU was quite promising in that it put specific safeguards in place to maintain the legitimacy and impartiality of the oversight body. While the SIU may not represent an ideal model of police oversight, it has made significant progress that cannot be ignored. The SIU model serves as an important model for any jurisdiction considering the reform of its system of investigating police wrongdoing.

The SIU is a civilian-led agency in which the *Police Services Act* prohibits police officers or former police officers from assuming the position of Director. It also prohibits any “serving” police officers from being appointed as SIU investigators. Unlike most other jurisdictions, the SIU is actually prohibited from using seconded police. As a result, the SIU employs “former” (in some cases retired) police as investigators. While many argue that using “former” police still results in police investigating police, there is a fundamental difference between using “former” police and using “seconded” police. If a jurisdiction insists on some kind of police involvement, using former police is essentially the lesser of two evils. As a safeguard against bias, SIU investigators are prohibited from being involved in investigations pertaining to the police department that once employed them. As a result, maintaining objectivity is much more feasible than in systems using seconded or internal police.

Recently, several other Canadian provinces have followed in the footsteps of Ontario and implemented their own models of police oversight. These include the Alberta Serious Incident Response Team (ASIRT) and Saskatchewan’s Public Complaints Commission (PCC). Still other provinces are in the process of establishing police investigative agencies, such as the Independent Investigative Unit (IIU) in Manitoba, and Nova Scotia’s yet to be announced investigative agency.

a. Alberta Serious Incident response Team

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

ASIRT uses a blend of civilians and seconded municipal, as well as RCMP, police officers who work together on investigations. Their mandate is to investigate incidents or complaints involving the serious injury or death of any person, and matters of a serious or sensitive nature that appear to have resulted from the actions of a police officer, in accordance with s. 46.1 of the Alberta *Police Act*.²⁹

46.1(1) The chief of police shall as soon as practicable notify the [provincial police] commission and the Minister [of Public Safety and Solicitor General] where

- (a) an incident occurs involving serious injury to or the death of any person that may have resulted from the actions of a police officer, or
- (b) a complaint is made alleging that
 - (i) serious injury to or the death of

any person may have resulted from the actions of a police officer, or

- (ii) there is any matter of a serious or sensitive nature related to the actions of a police officer.

The Minister then refers appropriate cases to ASIRT for investigation. ASIRT has jurisdiction over all sworn police officers of the 13 police agencies within the province, both municipal departments and RCMP agencies working under contract. An amendment to the RCMP Act requires the force to work with the investigative body.

ASIRT is led by a civilian director, currently Clifton Purvis, a lawyer and Crown prosecutor who was seconded from Alberta Justice to become responsible for the establishment and implementation of ASIRT. As the civilian executive director, he is responsible for independent, objective investigations into s. 46.1 incidents. In addition to the director, ASIRT consists of a civilian assistant director (currently Roy Fitzpatrick, whose prior service includes the RCMP and the Calgary Police Service), two civilian criminal analysts, four civilian investigators, and ten sworn police officers (from the Calgary Police Service, Edmonton Police Service, and the RCMP), all of whom report to the director. According to s. 46.2 of the *Police Act*, the director of ASIRT is defined as a chief of police for the purpose of s. 46.1 investigations. However, ASIRT does not have authority over Alberta sheriffs who have been increasingly engaging in traffic law enforcement.³⁰

The ASIRT does not have the ability to self-initiate investigations. All complaints are forwarded by the Minister and the investigative agency does not take complaints from the public. After the completion of an ASIRT investigation, the ASIRT director reviews the results

of investigations to ensure completeness and fairness. A report can be forwarded to the Office of the Crown Prosecutor requesting an opinion on whether charges should be laid. The director has the authority to decide what charges, if any, will result from the investigation.

Although relatively new, ASIRT has successfully completed numerous investigations, and appears to be struggling to meet the demand for its service (Handysides, 2009). ASIRT completed its first investigation in November 2008 and in early 2009, for the first time, laid criminal charges when an RCMP officer was charged with sexual assault (Metro Edmonton, 2009). In June 2009, a Calgary Police Service officer was charged with the cybercrime offence of luring a child following an investigation by ASIRT (Canadian Press, 2009a). After an ASIRT investigation, an Edmonton RCMP officer was charged with numerous counts of assault in an incident involving a family dispute (Canadian Press, 2009b). Following an investigation into an alleged assault by an Edmonton officer, a charge was laid in October 2009 (Sun Media, 2009). Additionally, charges of assault and obstruction were laid against an RCMP officer working in Lac La Biche for injuries sustained by an individual in police custody (QMI Agency, 2009). To date, no police-involved deaths have resulted in ASIRT recommending charges be laid.

Evaluation of ASIRT

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

Since ASIRT has no powers to initiate investigations on its own, it is reliant on the Ministry of Public Safety and Solicitor General to provide it

with appropriate cases to investigate. Cases of police-involved deaths and serious injuries may be allocated to ASIRT; however, the Ministry retains discretion to withhold these cases from the agency and allow another police force, or even the force in which the incident arose to conduct the investigation. While there may be rare cases of death or serious injury arise in which it is appropriate for the agency involved in the incident to do the investigation, it would clearly increase public confidence if it was ASIRT itself that was exercising discretion to allow the home agency to investigate rather than the Ministry responsible for policing in the province.

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

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

- A fracture or combination of fracture and severe trauma to a limb, rib or vertebrae or to the skull including the probability of a head injury;
- Burns or abrasions to a major portion of the body;
- Loss of any portion of the body;

- Loss of mobility (paralysis) of any portion of the body;
- Loss of vision or hearing;
- Injury to any internal organ;
- Loss of consciousness brought about by a state of extreme mental distress, prolonged agitation and/or combative behavior which collectively may be classified as symptoms of excited delirium.

Serious injury shall be presumed in instances where a prolonged delay may be likely before the nature and seriousness of injury can be assessed

Serious injury will be presumed in ALL instances where:

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

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

- A firearm was discharged at a person by a police officer;

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

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

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

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

a. Saskatchewan Public

Complaints Commission

Saskatchewan’s Public Complaints Commission (PCC) was created in a specific effort to

increase public confidence in the accountability of police. Additionally, the PCC was created to improve the relationship between Saskatchewan's Aboriginal population and the police. The development of this Commission was part of the government's response to both the Stonechild Inquiry and the Commission on First Nations and Métis Peoples and Justice Reform (Government of Saskatchewan, 2006). The PCC became operational in April 2006 and replaced the office of the Saskatchewan Police Complaints Investigator (PCI).

The Public Complaints Commission is an independent, non-police body, consisting of five individuals, including a chairperson and vice-chairperson.³¹ Members of the board are appointed by the Lieutenant Governor in Council for a three-year term, with the possibility of one renewal. As of 2005 amendments to the legislation, the composition of the board must include at least one person who is: of First Nations' ancestry, Metis ancestry, a lawyer (Province of Saskatchewan, 2008). This provision ensures the board is representative of Saskatchewan's population and has someone with the necessary legal expertise. The PCC investigative staff consists of civilians and retired/former police officers from local police forces, the federal police force, or abroad.

The five-person commission is headed by a director. The director, at present John A. Clarke, is responsible for the daily operation of the PCC. The PCC legislation required consultations to be conducted with the Saskatchewan Association of Chiefs of Police, Federation of Saskatchewan Indian Nations, Saskatchewan Federation of Police Officers, and local police boards prior to appointments onto the commission. Consultations have been conducted with the Métis Family and Community Justice Services.

The role of the PCC is to receive, investigate, and review complaints against the police or pos-

sible criminal offences committed by police. The PCC has direct control over who conducts the investigation into any public police complaint, including criminal matters. It is also able to complete an investigation into a criminal allegation against a member or chief of police even after that member or chief resigns. The commission has jurisdiction over all municipal police officers in Saskatchewan. However, RCMP members make up a very large proportion of the police serving in that province, and the PCC is expected to play a role in their oversight due to the recent announcement of the RCMP Commissioner to allow provincial investigative agencies to investigate serious RCMP wrongdoing.³²

When determining how an investigation of a public complaint should be handled, the PCC has the following four options available to them: 1) investigation by the PCC itself, using the PCC's investigative staff; 2) investigation by the police service whose member is the subject of the complaint; 3) investigation by the police service whose member is the subject of the complaint with the assistance of an outside observer who is appointed by the PCC to monitor the investigation and report back to the PCC; or, 4) investigation by a separate police service (i.e. other than the police service whose member is the subject of the complaint). Where appropriate, complaints can be resolved through mediation or informal resolution.

In cases involving serious injury or death, the municipal police service or RCMP detachment concerned must request that the Deputy Minister of Justice appoint an investigation observer "from another police service or detachment of the RCMP" to oversee the investigation.³³ This observer monitors the investigation and reports back to the Deputy Minister, not the PCC.

Evaluation of the PCC

The PCC is an agency specifically designed to impartially review and resolve complaints

against the police. In addition, it was created in an effort to increase public confidence in the accountability of police. This commission is quite unique in its orientation and make-up. It consists of five civilians chosen to reflect the general make-up of Saskatchewan's population. While no member of the panel can be a former, retired or active police officer, members can be reappointed for a second term, and thus there is arguably some incentive to seek government favour which could compromise the panels' independence. It is notable that the panel or board has complete power and discretion to determine how to proceed with an investigation. However, all of the options available to the PCC involve using "active" police to investigate police. In fact, one of the options allows the very police department whose member is the subject of a complaint to investigate. This is very reminiscent of the system historically used in B.C. to investigate alleged police wrong doing.

The PCC model's main strength comes from its panel which consists of civilians, representing an impartial, neutral, and legitimate oversight body. However, the PCC has very limited options available to it in handling investigations. If investigations are not handled by the PCC itself, then what remains are unsatisfactory alternatives. Although having a PCC observer monitoring an investigation by the police gives a small sense of comfort in the reliability of the outcome, allowing police to investigate police without any management, supervision, or assistance by civilians is not a viable option. It is problematic that this is still available as an option and is a major flaw in the PCC model.

a. Manitoba Independent Investigation Unit

In the winter of 2005 in East St. Paul, Manitoba, an off-duty police officer from Winnipeg who had been drinking collided with a car, killing its occupant. The investigation that followed was soundly criticised as unprofes-

sional, and in some aspects, based on bad faith (Salhany, 2008). The incident gave rise to the Taman Inquiry, a commission of inquiry conducted by Justice Roger Salhany (2008). The commission found the police officer involved in the incident was given different treatment by the police investigators than a non-police officer would be likely to receive in the same circumstances. As a consequence of the botched investigation, no alcohol-related charges were brought against the officer and his subsequent conviction for dangerous driving causing death resulted in a community disposition, perceived by many as overly lenient. A key recommendation in the inquiry report was for Manitoba to create an independent unit to investigate any alleged criminal activity committed by police officers (Salhany, 2008, p. 139).

In the spring of 2009, the government of Manitoba announced its decision to create an Independent Investigation Unit (IIU) to investigate deaths in custody and cases resulting in serious injury involving police. Manitoba is one of the latest Canadian provinces to make such a move. Under the new *Police Services Act*,³⁴ the IIU is responsible for investigating the following incidents: death or serious injury that may have resulted from the actions of a police officer, contraventions of prescribed provisions in the *Police Services Act Regulations* that include certain offences under the *Criminal Code* and other enactments (s. 65), and any other cases involving allegations of illegality against police where there is a public interest in an independent investigation (s. 75).

In the new legislation, the protocol for handling less serious criminal allegations requires police services to immediately inform the IIU of a complaint. Following this, the IIU may monitor investigations conducted by professional standards units that are internal to police services. Additionally, the IIU has the power to take over any investigation. Police services are required to

report the results of investigations to the director of the IIU, and police professional standards units must do any follow-up investigations directed by the IIU (Government of Manitoba, n.d.). All non-criminal complaints are dealt with by police services or the Law Enforcement Review Agency (LERA), an independent agency responsible for investigating complaints regarding minor wrongdoing by municipal police officers in the province. Complaints pertaining to police policy are the responsibility of the local police boards and chiefs of police.

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

The IIU will be led by a civilian director who is independent of all police services. The duties and powers of the director are set out under the new *Police Act* provisions. The director of the IIU reports to Manitoba Justice and operates independent of all police services. The government claims the IIU will be staffed with

“highly skilled investigators from police services in Manitoba and assigned to the unit” (Government of Manitoba, n.d.). The director may employ the use of civilian investigators “who meet the standards under the act”. At the moment, the IIU appears to be in the process of hiring its staff. When fully operational, the IIU will operate from its own independent office in Winnipeg. Based on the nature of a complaint or incident, the director of the IIU must contact the Manitoba Police Commission to assign a civilian monitor to a case.

Evaluation of the IIU

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

There are numerous positive aspects to the new IIU model. First, the IIU's mandate includes the ability to investigate conduct of off-duty police officers as well as those who are on-duty. Indeed, this is a necessary provision that all police oversight models operating in all jurisdictions should adopt in their mandates. There have been too many cases where a police officer in question was “off-duty”, thereby negating the application of external investigation mechanisms.³⁵ In fact, some recent high profile cases involving off-duty conduct resulted in death or serious injury to a member of the public.³⁶ Even though a police officer is “off-duty”, it is still expected that their conduct will comply with the standards expected of a police officer sworn to uphold the law.

It is notable that the IIU model proposes the

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

While the IIU has followed other models by using a civilian director, it has also made the same mistakes as several other models in allowing IIU investigators to be serving or ex-police officers. A point of major concern with this model is that it allows for the use of police from the force that is under investigation. The use of "civilian investigators" is envisioned under the Act, but only those individuals "who meet the standards under the act" will be considered for employment in that role. ASIRT's model is based on a similar provision in the Alberta legislation, but the civilian investigators are entirely comprised of retired and other ex-police officers. It is hard to imagine that the IIU will be any different in this regard. Indeed, the Attorney General at the time of the amendments accepted that police will continue to investigate police under the new regime:

...(AG) Chomiak said there could be some controversy over how officers will be assigned to the investigative unit. They can either be current or former police officers selected by a civilian director. Current police officers would be seconded from their police service. 'To be logical, that's probably what it will have to be,' Chomiak said. 'Investigators don't sort of grow on trees.' Chomiak said such a selection process may create a perception of bias, in that some of the officers in the unit would still be connected to the police service they're investigating. 'Clearly, when you bring in a rewrite of a police act, you cannot meet everyone's expectations, but to the extent that we were able to manage the various interests, I think that this act goes some way towards modernizing and producing a made-in-Manitoba model that we had promised after the Taman Inquiry and that had been asked for in the AJI [Aboriginal Justice Inquiry].' (Owen, 2009).

The IIU may also employ civilian monitors to "observe" investigations of police officers. However, despite how many "civilian monitors" are used, if the investigations themselves are still being done by police, the quality of the investigation is open to question by the public, with a strong perception of bias that cannot be ignored. The use of seconded officers was soundly criticised in the Manitoba media:

Mr. Chomiak speaks like a man who has listened to those who argue that entrusting investigations to outsiders would be a mistake. This ignores that experience has shown. Winnipeggers learned from the J.J. Harper and the Taman scandals that police investigating police can and do screw up with huge consequences for police credibility... The new unit... should establish its own training protocol so it can recruit from a wide pool of candidates who have the acumen the job requires (Winnipeg Free Press, 2009).

Manitoba's new IIU model has some positive aspects to it that should be considered by other jurisdictions. However, it also seems to be yet another example of a faulty system of police oversight that still results in police investigating police in the majority of cases.

a. Maritime Provinces

In late 2009, Nova Scotia announced it was going to create an independent agency to investigate allegations of serious police wrongdoing (CBC News, 2009d). David Burchill of the Nova Scotia Department of Justice recently indicated that Nova Scotia is well on its way towards adopting an independent investigative unit.³⁷ While the composition and the scope of the mandate for the new unit has yet to be ascertained, it is clear that the unit will have a civilian director who will be a non-police officer, likely a person with experience as a prosecutor or a retired judge. Nova Scotia officials have been in consultation with their counterparts in neighbouring Maritime provinces, exploring the possibility of a regional unit, or a unit with regional representation, permitting the use of the new agency to investigate allegations of police wrongdoing in those provinces. It is expected that Nova Scotia may adopt legislation establishing the new unit in late 2010. To date, neither New Brunswick nor Prince Edward Island appear to be interested in establishing their own independent investigative unit.

b. Quebec

In Quebec, the Public Safety Minister has established policy to govern the investigation of deaths and serious injury cases arising from police involvement. That policy requires police from a force other than the one directly involved in the incident to conduct an investigation and make a report to the prosecutorial authorities who decide whether charges are to be laid. In February 2010, the Quebec Ombudsman released a report that looked into this

policy governing the investigation of police-involved deaths and serious injuries, producing criticism of the process and recommendations for change (Quebec Ombudsman, 2010).

c. British Columbia

British Columbia has witnessed a number of high profile cases involving allegations of serious police wrongdoing. However, it has been slow to react to the legislative developments arising elsewhere in Canada. In 1994, Justice Oppal, then sitting on the B.C. Court of Appeal, conducted a sweeping review of policing in the province. Included in his final report were recommendations for the reform of the police complaints and investigation process. One of his recommendations called for the creation of a civilian police complaints commission (which occurred in 1998) which should have the authority to supervise police investigations of complaints and call them to account for their investigations (which did not occur), and a power to actually conduct investigations in appropriate cases (which also did not occur). The current powers of the police complaint commissioner in B.C. are generally restricted to receiving complaints, providing informal mediation, and ordering a public inquiry in appropriate cases.³⁸ In recent years, the office of the police complaint commissioner has also taken on the task of overseeing internal police investigations through the review of reports submitted by the professional standards investigators of the police agency conducting an investigation. In 2007, the B.C. government again heard from an inquiry that recommended changes to the process for investigating allegations of wrongdoing by the police. In his *Review of the Police Complaint Process in B.C.*, former B.C. Supreme Court Justice Josiah Wood called for enhanced civilian oversight of police investigations of police wrongdoing. In 2008, former B.C. Supreme Court Justice William Davies conducted an inquiry into the death of Frank Paul, a man

who had been in the custody of the Vancouver police immediately prior to his death. In his report, Mr. Davies soundly criticised the notion that a police department should be allowed to conduct the investigation of a death connected with that very same department (as was the case in this incident). He recommended that police-involved deaths be investigated by a genuinely independent civilian agency.

In recent years, particularly following the criticism that attached to the Frank Paul investigation, high profile cases of alleged serious police wrongdoing have been referred to an outside police agency for investigation. However, this often occurred in tandem with internal investigations. In all cases, the initial portion of the investigation including securing evidence and taking initial witness statements was always conducted by officers belonging to the same police agency as the officer who is alleged to have committed the wrongful acts. Following the flurry of reports calling for change in B.C., the provincial government finally responded with a legislative amendment to the police complaint provisions of the B.C. *Police Act* in 2009. In 2010, the amendments to the *Police Act* were brought into force, instituting a new procedure for dealing with alleged serious police wrongdoing. The new scheme formally authorizes the external investigation of serious police wrongdoing.³⁹ However, this recent response represents a minimal change in that it does nothing more than reflect the existing practice of using neighbouring police departments to conduct investigations, a practice that has been followed as a matter of course in serious wrongdoing cases over the past several years.

The new scheme for investigating serious police wrongdoing in B.C. does not envision the development of an external civilian agency, or even an external police-staffed agency with a civilian head. Instead, it uses police from other police agencies in the province to carry out the inves-

tigation of allegations of serious wrongdoing.⁴⁰ This process is only used for cases resulting in death while in police custody or care, cases in which serious harm has been suffered, and in cases of reportable injuries. Serious harm is not defined in the *Act*, but s. 89(5) allows the police complaint commissioner to issue guidelines in this regard. Reportable injuries are defined in s. 76 of the *Act* as including those resulting from the use of a firearm, those requiring hospitalization and those prescribed by regulation. In addition to these scenarios, an external investigation may be ordered by the police complaint commissioner where that official finds it to be “necessary in the public interest” to do so.⁴¹ Similarly, a police chief who finds an external investigation of an officer’s conduct to be in the public interest may order such an investigation, provided the police complaint commissioner approves of this measure.⁴² The police complaint commissioner may also order the investigation of a municipal police officer’s conduct, even where no formal complaint has been filed.⁴³

If a police officer from another police agency is appointed to investigate an allegation of police wrongdoing, the investigating officer must have no connection with the case, and must of a rank equivalent to or above the officer being investigated.⁴⁴ The police complaint commissioner is entitled to “observe” any investigation ordered under Part 11 of the *Police Act*.⁴⁵ Monitoring of ongoing investigations is authorized through s. 97 of the *Act* which allows the police complaint commissioner to require the investigating officer to keep the commissioner or his observer informed of the progress being made in the investigation, including providing copies of records where required.⁴⁶ The complaint commissioner may also provide advice to investigators and direct that further investigative steps be taken,⁴⁷ provided the commissioner has consulted with the investigating officer and his chief.⁴⁸ Investigators are granted various powers to aid them in their investigation,⁴⁹ and a duty is

imposed on officers being investigated to cooperate, answer questions, and provide a written statement pertaining to the incident being investigated if requested to do so,⁵⁰ and all persons must refrain from hindering investigations.⁵¹

Evaluation of the B.C. Model

Considering British Columbia is one of the latest provinces to amend its process for investigating allegations of serious police wrongdoing, one would expect it to have one of the most progressive and fully developed systems. This could not be farther from reality. While civilian investigation and civilian-led investigation are rapidly becoming the norm in the rest of the jurisdictions that have turned their attention to these matters in recent years, B.C. maintains a process that involves the investigation of police officers by other police officers. These individuals are not accountable to a civilian head in any meaningful way. These investigations are conducted by nearby police agencies, ones with which many police officers no doubt have longstanding connections.⁵² Investigation of the police by another police agency does little to instill public confidence in the impartiality and thoroughness of an investigation. While the police complaint commissioner is entitled to observe these investigations, and even to provide advice and direction for further investigation, this does little to assuage concerns that the process remains under the control and direction of the police.

The lack of a precise definition of “serious harm” may present problems for delineating the cases that are sent to external investigation.⁵³ To its credit, the Act does allow for an external investigation where the “public interest” mandates this response. Granting the power to police chiefs to order an external investigation where the public interest is best served by doing so is also a positive feature of the Act. However, it is odd that police chiefs are granted the authority to select the external agency that will conduct the investigation.⁵⁴ Leaving this

decision in the hands of the police complaints commissioner seems like an obvious step that would help to minimize the perception of bias.

The B.C. model is fundamentally flawed in its failure to employ an independent, civilian-run organization staffed by non-police officers. Any jurisdiction that is attempting to reform its process for investigating allegations of serious police wrongdoing must move to a more progressive model.

3. Substantiation of Complaints

The research on the proportion of complaints about alleged police wrongdoing that are substantiated is very limited in both volume and value. One would think that substantiation rates would increase once civilians take over investigation and/or civilians take control of the process governing the investigation of allegations of wrongdoing. Unfortunately, there is little research on this topic worldwide, and particularly scant attention has been paid to this in Canada. There is a small body of research examining the substantiation issue; however, the results tend to show that substantiation tend to be very low under any system of police oversight.

How to accurately calculate substantiation rates is a matter of some controversy. Of all cases concluded in a given year, some will be found to be substantiated, while others will be determined to be unsubstantiated. Yet, not all cases can readily be placed into one of these two categories. Some cases will be withdrawn, some will be affected by the lack of complainant cooperation, and yet others will be informally resolved or mediated away. If these cases are included in the total, the substantiation rate is usually affected quite significantly. If they are left out of the equation, useful data is lost. Some of the literature on substantiation rates uses total number of complaints as the denominator in calculating substantiation rates, while others use only those complaints

IPCC Results (Gleeson & Grace, 2009)				Smith Results (2005)		
	Substantiated	Total		Substantiated		Total
Year	N	%	N	N	%	N
1995/96	749	9	8,653	749	2	35,840
1996/97	834	8	10,820	834	2	36,731
1997/98	850	9	9,840	850	2	35,834
1998/99	745	8	9,202	745	2	31,653
1999/00	714	9	8,048	714	2	30,807
2000/01	903	9	9,842	903	3	31,034
2001/02	898	12	7,705	898	3	26,701
2002/03	941	13	7,262	941	4	24,562

Table 2: Substantiation of complaints in England and Wales

that involved a completed investigation where a determination of substantiation was made.

As a point of comparison, one can look at the reported substantiation rates in England and Wales, as compiled by the Police Complaint Commission itself, and contrast their numbers with those provided in a recent academic article:

The two sources agree on the raw number of cases that were substantiated; however, the use of a different total number of cases produces dramatically different substantiation rates. The IPCC (through Gleeson & Grace, 2009) calculates the substantiation rate based on the number of cases where an investigation was completed and a determination was made on the veracity of the complaint. Smith's (2005) approach is to calculate substantiation based on the total number of complaints dealt with in a year. Smith's total includes cases where the complainant withdraws their complaint, cases where an informal resolution was obtained prior to an investigation being completed, and other such cases. Under the Smith approach, if a new process for diverting suitable complaints is instituted (such as a mediation or informal resolution program), the proportion of cases resulting in a completed investigation can be expected to drop while the total number of

complaints will remain constant or increase. This will inevitably produce a reduced substantiation rate when, in fact, a greater proportion of complainants may be satisfied with the outcome of their case. To avoid this problem, and others related to it, the following discussion refers to substantiation rates of completed cases.

In B.C., substantiation rates have fluctuated, sometimes being incredibly low, but generally consistent with other jurisdictions. Recent reports by the Office of the Police Complaint Commissioner in B.C. are revealed in Table 3.:

Prior to reform of the police service in Northern Ireland, the substantiation rate for allegations against members of the Royal Ulster Constabulary (RUC) was reported to be less than 1% (O'Rawe and Moore, quoted in Ellison, 2007).⁵⁵ Recent statistics released by the PONI reveal a substantiation rate for allegations against members of the Police Service for Northern Ireland have ranged from around 9% to 18% (see Table 4).

It is noteworthy that a large caseload increase occurred in 2008/09 over the previous year, while the substantiation rate remained fairly consistent from the prior year.

In England and Wales, data on substantiation

British Columbia Police Complaint Commissioner						
Outcome of completed investigations 2003-2009						
	Substantiated		Unsubstantiated		Subtotal*	Total**
Year	N	%	N	%		
2003	39	24	126	76	165	366
2004	30	15	174	85	204	393
2005	17	9	167	91	184	381
2006	57	8	618	92	675	1,027
2007	88	16	477	84	555	989
2008	117	18	523	82	640	989
2009	97	18	438	82	535	960

Table 3: Substantiation of complaints in British Columbia

*Cases in the subtotal are those that were either substantiated or unsubstantiated. Substantiated cases are those where, following an investigation, it was determined that the complaint was supported by the evidence. Unsubstantiated cases are those in which the evidence did not support the allegation of wrongdoing.

**The total number of concluded allegations includes, in addition to the substantiated and unsubstantiated cases, those additional cases that were withdrawn by the complainant, cases involving a review by the OPCC on a service or policy matter that was not a specific allegation, cases informally resolved or mediated, and those that were summarily dismissed. These are not included in the denominator for the calculation of substantiation rates, consistent with the approach taken elsewhere.

Police Ombudsman for Northern Ireland					
Outcome of completed investigations 2004/05 - 2008/09					
	Substantiated		Unsubstantiated		Total
Year	N	%	N	%	
2004/05	98	9	955	91	1,053
2005/06	170	16	908	84	1,078
2006/07	134	12	991	88	1,125
2007/08	208	17	1,014	83	1,222
2008/09	374	18	1,732	82	2,106

Table 4: Substantiation of complaints - Police Service of Northern Ireland

Note: Cases included as unsubstantiated include those classified as “ill founded” as well as those found to be unsubstantiated by the evidence. Cases where progress was halted are not included, nor are cases which were informally resolved. Source: PONI website.

rates has been published by the Independent Police Complaints Commission (IPCC) since its inception in 2004. Before this time, data on this topic was available less frequently. The most recent IPCC report reveals substantiation rates between 1995/96 and 2008/09 (see Table 5).

The major reforms to the police complaint process in England and Wales came into force part way through 2004. Unfortunately, substantiation rates did not rise dramatically following the adoption of the new civilian-based complaint and investigation process. The rates of substantiation have always hovered in the 8 to 13% range. If anything, a minor increase can be noted in 2001/02, the year before the Bill bringing about the creation of the IPCC was introduced into Parliament. Substantiation rates have remained remarkably constant since that time. However, it is noteworthy that the volume

of cases investigated increased almost twofold in the year after the IPCC came into operation, while substantiation rates remained constant.

Accessing data on substantiation rates in Canadian jurisdictions that have instituted police accountability reform is very difficult. Most jurisdictions have only recently instituted such reforms, making impact assessments premature. Ontario, the one jurisdiction that reformed its process several years ago (with the adoption of the SIU in 1990) has not made data on substantiation rates readily available. In late 2009, the Office of the Independent Police Review Director came into existence. This office was brought about through the adoption of the Independent Police Review Act, 2007, which makes the Director's office responsible for overseeing a new public complaints system in that province. Part of the Director's

England and Wales Independent Police Complaint Commission					
Outcome of completed investigations 1995/96 - 2008/09					
	Substantiated		Unsubstantiated		Total
Year	N	%	N	%	
1995/96	749	9	7,904	91	8,653
1996/97	834	8	9,986	92	10,820
1997/98	850	9	8,990	91	9,840
1998/99	745	8	8,457	92	9,202
1999/00	714	9	7,334	91	8,048
2000/01	903	9	8,939	91	9,842
2001/02	898	12	6,807	88	7,705
2002/03	941	13	6,321	87	7,262
2003/04	961	12	6,800	88	7,761
2004/05	745	13	4,840	87	5,585
2005/06	1,236	12	9,316	88	10,552
2006/07	1,389	11	11,294	89	12,683
2007/08	1,580	11	12,978	89	14,558
2008/09	1,810	10	16,327	90	18,137
Table 5. Note: does not include the British Transport Police					
Source: Gleeson & Grace, 2009, p27					

mandate is to publish annual reports which will contain information regarding case outcomes. Until the first report is released, it will be difficult to assess how Ontario's substantiation rate compares to other jurisdictions.

In the past, research by Tammy Landau on the complaints process in Toronto described the low substantiation rates in that jurisdiction. Historically, complaints of police wrongdoing that fall short of death and serious injury have remained within the purview of the local police chief to investigate. Landau's research revealed that chiefs dismissed about 97% of all complaints in the 1993-1996 period (Landau, 2000, p. 76). More current research in this field is lacking. There do not appear to be any studies looking at whether external civilian investigation or reviews of investigations are more effective than the use of internal police processes of handling complaints.

Policing research in the United States typically places substantiation of complaint rates at between 10% and 25% (Lersch, 1998; Lersch and Mieczkowski, 1996; Pate and Fridell, 1993). Recent research out of the US revealed only 1.6% of citizen initiated complaints about police misconduct were substantiated, while 69% of police complaints about fellow officers were substantiated (Liederbach, Boyd, Taylor and Kawucha, 2008, p. 369). Fairly recent research out of Norway reveals a police complaint substantiation rate of 7% (Thomassen, 2002). The Queensland (Australia) Criminal Justice Commission reported an 8.6% overall substantiation rate of police complaints in 1997 (Prenzler, 2000, p. 665). In Hong Kong, the independent Police Complaints Council reported a substantiation rate of 13.1% in 2004 (IPCC, 2004). Substantiation rates of between 2 and 8% have been identified as an "international phenomenon" for jurisdictions using civilian review of internal police investigations by Walker and Bumphus (1992).

Of course, it is very difficult to compare substantiation rates across different fields due to the different issues at stake. In these other arenas, substantiation rates for complaints processes vary widely. In the U.S., the military whistleblower program has historically had approximately a 25% substantiation rate (Inspector General, 2009, p. 14). The substantiation rate for alleged abuses in elder care nursing homes varies between 8% and 66% with a national average of 38% (Stevenson, 2006, p. 354). The Law Society of B.C. investigates complaints of alleged wrongdoing by local members of the bar. In 2009, they had a substantiation rate (as defined through referral to the Discipline Committee) of 13% (Law Society of B.C., 2010, p. 13). The College of Physicians and Surgeons for B.C. has an Inquiry Committee which reviews every complaint filed under the Health Professions Act. Of 72 files reviewed in 2009, they found 27 (37%) to be substantiated (College of Physicians and Surgeons of B.C., 2010, p. 20).

There are limitations to the current research on substantiation of complaints. There do not appear to be any studies in Canada that compare substantiation rates before and after civilian oversight or civilian investigation has been introduced into a police agency. There have been no comparative studies looking at substantiation rates or citizen satisfaction between jurisdictions in Canada that do and those that do not employ civilian oversight or civilian investigation. There appear to be no studies in Canada addressing whether civilian oversight or civilian investigation improves the relationship between the police and ethnic minorities.

4. Conclusion

British Columbia lags behind other democratic jurisdictions in its tardiness in adopting a civilian-led, civilian staffed agency to investigate allegations of police wrongdoing. Most other Commonwealth jurisdictions, including most of Canada's provinces have made significant

strides towards a model of police investigation that can be trusted as being unbiased. B.C. should move quickly to employ a model that is at the forefront of developments in this area, rather than making minimal efforts at change, tinkering with a system that is flawed at its core.

If complaints about police conduct are to be taken seriously, systemic changes are required. It has recently been noted that a number of

factors influence a complainant's decision to come forward with an allegation of wrongdoing. Among these are the seriousness of the allegation, the self-confidence of the complainant, their confidence in the system, and the availability of support and guidance (Smith, 2009). An ideal system is one in which all of the above are present. A minimally acceptable one is a system in which complainants at least have confidence in the system itself being unbiased.

Chapter 4

Barriers to Change

a. Arguments Against Independent Oversight/Investigation

Most of the resistance to independent police investigation appears to come from the police themselves. Police officers often advance arguments favouring maintaining the status quo, requiring allegations of police wrongdoing to be investigated by fellow police officers. They also appear to adopt an approach that emphasizes the rights of the accused officer to be presumed innocent, and call for a heavy burden to prevail on their accusers to establish wrongdoing. These are in marked contrast to the views expressed by many police officers regarding the recognition of such rights for accused persons who are not police officers, facing prosecution in the criminal courts. Various arguments advanced by the police for maintaining the prevailing system of self-investigation follow.

i. Only Police Are Competent

A common line of argument against genuine civilian investigation of alleged police wrongdoing is that only police officers are competent to carry out the investigation of serious police wrongdoing, since only police officers with many years of investigative experience have the necessary knowledge, skills and abilities to conduct a competent investigation. It has been claimed that the stakes involved in these investigations are so high that they can not be trusted to what the police perceive to be amateur investigators. Allegations of serious police wrongdoing may involve actions bringing about death or serious injury to an individual. Serious or major crime investigators have typically made a career out of investigating such incidents in the community at

large. Police often argue that no other segment of the population is involved in such investigations, and accordingly, it is not possible to find civilian investigators with the necessary skill set to carry out a complex criminal investigation.

Proponents of the status quo argue that it takes many years to learn to become a good investigator. They argue that these skills can not be adequately attained outside the police training and experiential envelope. Only a handful of police officers in each police department are responsible for conducting serious crime investigations. Even among senior police personnel, many believe they could not walk into the role of serious crime investigator without considerable training. Since police officers are experienced investigators themselves, they are unlikely to stand for incompetent investigations being carried out in regard to them.

This claim is open to serious doubt. There is nothing special about the kinds of people recruited into policing that makes them inherently better investigators than others. Police investigators become good at what they do through training and experience. This is something that can be done with non-police investigators. Furthermore, the typical police wrongdoing case is much simpler than the typical case encountered by serious crime investigators in police agencies. For them, the biggest question is often figuring out who committed the crime. In police wrongdoing cases, the officer alleged to have wronged another is usually very easy to identify. These

cases are usually well documented, and there are often numerous police witnesses available to interview for the purposes of the investigation.

ii. Self-Policing Reflects Professionalization

A frequent refrain in the civilian investigation of police debate is that self-policing is an essential component of professionalization. It is frequently asserted that other professions, such as medical doctors and lawyers, have investigations of allegations of wrongdoing among members of the profession carried out by members of that same profession. Professional associations, such as the Law Society for lawyers and the College of Physicians and Surgeons for medical doctors are said to be made up of members of these professions and that these people carry out the investigation, and even adjudication of alleged wrongdoing.

In actuality, the process of investigating alleged wrongdoing in many professions varies widely. Medical doctors who are alleged to have committed wrongdoing in B.C. will have a College of Physicians and Surgeons staff person collect relevant information that is forwarded to an Inquiry Committee. That committee reviews and discusses the information, and may interview witnesses. However, the committee is not wholly composed of medical doctors. There are always non-physicians with various areas of expertise on these committees in addition to physicians. Those unsatisfied with the committee's findings may appeal to a Health Profession Review Board, a board chaired by a lawyer and composed of non-physicians appointed by the provincial government.

Members of the legal profession in B.C. are investigated for alleged wrongdoing by staff working for the Law Society. The investigating staff are varied in their backgrounds, including lawyers, forensic accountants, former police officers, and others. Should the incident merit in-

volving the discipline process, the matter will be brought before a discipline committee of the Law Society. The discipline committee will be made up of Benchers, who are lawyers elected by the profession, and possibly other practicing lawyers; however, at least one of the members of the discipline committee will be a Lay-Bench-er, a non-lawyer appointed by the province to the governing body of the Law Society.

The mechanisms set up to facilitate the investigation of alleged professional wrongdoing among the various professions typically pertain to a wide range of wrongdoing. However, serious wrongdoing will almost invariably be accompanied by an external investigation, carried out by the police. This begs the question of who should carry out the internal investigation of serious wrongdoing when the alleged wrongdoers are the police themselves.

iii. Independent Investigation Sends a Message Police Can't Be Trusted

If you can not police yourself, then who can you police? Taking the investigation of alleged police wrongdoing out of the hands of police investigators may send a message that the police should not be trusted to carry out any investigations at all. This is a complaint that may be advanced regarding the police being divested of the responsibility to investigate fellow police officers.

A contrary argument is that police can be trusted when they maintain transparency and accountability through a legitimate accountability structure. Failure to adhere to the basic principles of democratic governance is likely to do more to harm public perceptions of police trustworthiness than placing the responsibility for investigating wrongdoing into the hands of an external agency.

The police in British Columbia have done a terrible job of maintaining the public trust in recent years. Over the past several years, in-

stances of police abuse of authority, internal corruption, misinforming the public, and applying a double standard that has seen many police officers escape accountability for alleged wrongdoing have done more to harm the reputation of the police than the prospect of taking away their capacity to self-police. If anything, it can be expected that public respect and trust in the police will increase once a regime of transparency and accountability is in place.

iv. External Investigation Fosters a Culture in Which Police Become Less Ethical

It has been argued that taking control of the investigation out of the hands of those responsible for the wrongdoing divests the agency of the responsibility to remain ethical. The Police Ombudsman for Northern Ireland has asserted: “oversight systems, in some cases, cause police to abdicate their own responsibility to self-regulate conduct and maintain public trust and confidence...” (Hutchinson, 2005). He is making the claim that police need to retain the responsibility to self-regulate their behaviour, and that the creation of an external oversight mechanism has the undesired effect of diminishing self-control thereby exacerbating conduct.

Being invested in one’s job likely has a positive effect in overall performance, including maintaining ethical conduct. However, it is difficult to envision how adding a layer of accountability will, in itself, lead to a decrease in ethical conduct. Commitment to an organization should be fostered through effective leadership as reflected in organizational management and administration, not by putting the police in charge of policing themselves.

Having a vigorous oversight process in place may have a deterrent impact on wrongful police conduct. If police believe their improper actions are likely to be critically investigated, it seems safe to assume they will

be less likely to engage in the type of behaviour that is likely to draw such investigation.

v. Excessive Oversight Has a Dampening Effect on Effective Police Practice

Concern that one’s actions will be subject to excessive scrutiny may have an inhibiting effect on one’s ability to do the job. If a police officer is overly concerned that their every action will be put under a microscope, they may be reluctant to take action where it is necessary to properly fulfil their policing responsibilities. This has been advanced as an argument against moving to a civilian-run oversight system.

The police are used to working in an environment in which their decision-making is subjected to post-hoc scrutiny. Police are routinely accountable to their supervisors for decisions they make, and they are also routinely held accountable for their exercise of discretion by the courts. Police must justify their requests for warrants, and will inevitably have to explain their use of police powers should cases they are involved in make their way through the courts. Illegally obtained evidence is often excluded from trials, and the police always operate under the knowledge that they may be held liable for failing to meet the standard of care expected of them, in civil court, even if not very frequently in criminal court.

Concern that the police will begin to think twice before exercising their considerable powers should not be perceived as a negative thing. Indeed, it is the intended objective of a system of proper oversight. The rule of law requires that the police be subjected to the application of law the same as any other members of society. They can not be given an exception simply because their job is one that requires careful thought and consideration of the legal repercussions of the decisions they make.

b. Police Subculture and Police Personality as Barriers to Reform

The police are a conservative group that is resistant to change. They are also a group composed of individuals with a like-minded world-view that has been the source of considerable problems when it comes to openness and transparency. This subculture and working personality may be part of the problem with investigations of police-involved deaths.

As a group, police officers have been found to work within an occupational subculture that has its own norms, values and other characteristics that are fairly unique. Among the major findings that the academic literature has pointed to, policing is characterized by:

- (1) Social isolation – police officers tend to stick to themselves, providing each other with mutual support.
- (2) Perception of the public as hostile – the public is viewed as unappreciative of police efforts.
- (3) Informal code of conduct – secrecy and loyalty to one another are expected and reinforced.
- (4) Working personality – policing comes to be adopted as an identity that shapes the personality of individual officers, affecting their world-view and shaping their interactions with others (MacAlister, 2004).

These aspects of the police subculture have a clear impact on the police organization. One of the most profound impacts is officers' desire to remain cloistered, look after one another, and resist whatever is perceived to be outside interference:

Insulation from the public, from the rest of officialdom, and from other police agencies may

enhance group loyalty and esprit de corps, both of which are desirable. But insularity also may breed abuse, violence, and secrecy. When insularity exists in an agency headed by a charismatic chief executive who has managed to move beyond accountability, police mistreatment, excessive force, and secrecy have proved virtually inevitable (Skolnick and Fyfe, 1993, p. 134).

c. Police Culture and Resistance to Change

Police culture is generally acknowledged as a major impediment to the investigation of alleged police wrongdoing, particularly in light of the “wall of silence” that accompanies the culture (see eg. Skolnick, 2002). Most of the relevant literature involves looking at line-level police officer resistance to reform and discusses the merits of a shift to community policing or problem-oriented policing. For example, Skogan outlines the need to anticipate opposition to such change by attempting to anticipate the approach of police unions, local politicians and the public (Skogan, 2008). Research shows that where community policing is added as an adjunct to other police units, members of such units are stigmatized and treated as outsiders by the police culture (Garcia, 2005). Very little literature exists on subcultural resistance or adaptation to oversight reform.

Efforts at bringing about organizational change in New South Wales, Australia during the 1980s were criticized as unsuccessful due to prevailing racist and abusive attitudes among the police towards aboriginal communities (Chan, 1996). Jerome Skolnick has identified the police subculture as one of the major impediments to effective police reform, arguing that any change must seek to “reduce the factors that contribute to the strength of the police subculture” if the reforms are to be effective (Goldstein, 1990, p. 30). He notes that police are likely to be highly resistant to change in their day-to-day practices.

In England, one researcher has claimed that “the police service has been the most effective [public] organization in *resisting reform* and *subverting modernization*, particularly in terms of the change agendas initiated by the ‘new public management’ movement in the eighties and nineties” (Savage, 2003, p. 171). The public sector reforms Savage referred to were largely centred around fixed term contracts for senior management and performance-related pay assessments. However, the reform agenda also included increased accountability as reflected in changes to prevailing accountability structures, including the institution of the Independent Police Complaints Commission in England and Wales, and the adoption of the Police Ombudsman in Northern Ireland (p. 180). Savage notes that these reforms, brought in by “New Labour”, were adopted against relatively little police resistance because the “political climate is one in which the *perceived necessity* of allowing the police sector to enjoy privileged status, and as such maintain the *reform-resistant* ethos of the past, has withered.” In essence, he asserts the decline in force behind law and order politics meant the police were less able to resist such changes. In Canada, the strength of law and order politics has done anything but diminish in recent years, leading to the conclusion that a similar lack of resistance to change can not be expected here any time soon.

Recent commentary has attended to the situation in England and Wales regarding police resistance to reforms following the Stephen Lawrence inquiry in 1999 (Macpherson, 1999). The Stephen Lawrence inquiry looked into the police investigation of a black murder victim in London, finding a flawed investigation and a police service marred by institutional racism. Among the recommendations flowing from the inquiry was a call for the police to make a record of all stops. Police viewed this requirement as an attack on the police service (Shiner, 2010). In his interviews with police officers involved in

the implementation of this requirement, Shiner found the police engaged in minimal compliance, and then turned the recording requirement away from its initial purpose as a check on racist police practices, using it as a means to gather and maintain criminal intelligence (2010, p. 14).

Northern Ireland is one jurisdiction where there appears to have been minimal internal resistance to the adoption of major reforms, including the implementation of a Police Ombudsman investigation/oversight system. The police service in Northern Ireland went through a major organizational shift following the release of the Patten Report in 1999 (Independent Commission on Policing, 1999). This came on the heels of the Good Friday Agreement in 1998, which brought about major political change in Northern Ireland, devolving power to the region and instituting altered political structures aimed at breaking down previous religious divisions. Police reform was one element in a major political restructuring in the region. That restructuring involved abandoning a colonial style of policing, and the adoption of a locally controlled community policing style (McGloin, 2003). Beyond this, the entire system of policing in Northern Ireland was altered at the same time the Police Ombudsman was adopted. That change involved a change in name (from Royal Ulster Constabulary to Police Service for Northern Ireland), a change in training (with a heavy emphasis on human rights), a change in hiring practices (actively recruiting minority Catholics into the ranks) accompanied by the encouragement of early retirement for older officers, and a change in mandate with a heavy emphasis on the protection of human rights (Bayley, 2008; Engel and Burruss, 2004).

An important aspect of the changes which have been so productive in Northern Ireland may have been the commitment to reorienting the police service towards an emphasis on fundamental rights and liberties. Michele Lamb

(2008) shows how the Northern Ireland reforms that resulted in the adoption of a new organizational ethos based on the human rights notions of “tolerance, fairness, dignity and respect” were infused into the police force, restructuring the culture of the police agency (p. 388). If this can be effected elsewhere, it offers considerable promise to reform policing in a way that diminishes the adverse impact of the police subculture on those reforms.

Janet Chan (1996) has argued that police organizational change is possible; however, it requires deep level reform, not simply a change in the rules of the game (or legislation governing the police). It involves a change in cultural knowledge, altering the basic assumptions and beliefs of police officers. The basic assumptions held by police officers regarding what their objectives and mandate are must be altered. Changes to the police mandate must be accompanied by genuine change in the performance evaluation criteria used for the police, for there is no point in formally promoting a change but continuing to reward past behaviour practices. These changes need to be supported by a change in the structural arrangements of power and authority in society (what Chan calls changes in the “field”) if there is to be real hope of long-lasting change in police behaviour. In this vein, Chan’s calls for reform are echoed by Marks,

This requires not simply a change in policy and training, but also in the belief systems and practices of managers and their performance management practices as well as a constant review of everyday practices and the consequences of those practices. Added to this, changing the field is complicated. Not only does the very organization of the police need to change structurally, but the power relations (broadly defined) within society need to transform. This involves, among other things, changes in societal economic and social conditions that allow disadvantaged groupings ac-

cess to networks of power to challenge police abuses and misconduct (Marks, 2003, p. 240).

d. Organizational Stasis

Police organizations have never been known for being particularly forward thinking, progressive organizations. In Canada, municipal police agencies were historically modeled on the English model of policing developed by Robert Peel in the early 1800s (Schmallegger et al, 2004, p. 103). The RCMP was modeled on the Royal Irish Constabulary, a paramilitary police organization developed to police rural Ireland in the early 1800s (Schmallegger et al., 2004, p. 101). Both of these models were very militaristic in structure and organization. Many of the characteristics of police organizations have remained unchanged for over a century.

Police organizations appear to be very slow to change: “compared to other organizations, the rate of change in police organizations has to date been shown to be slow and incremental in nature” (Seagrave, 1997, p. 125). The reasons for this can likely be found within the nature of the police subculture and the nature of police leadership.

As noted above, the police subculture tends to be very conservative and resistant to change. This attitude transcends front-line level police culture into police management subculture. Historically, promotion within the ranks of the police has appeared to have more to do with length of service than with leadership ability. Accordingly, it is individuals who have been well socialized in to the police subculture who take on management level jobs in policing. Similarly, many police organizations historically identified and promoted individuals to the senior ranks from within the police organization rather than shopping externally for top management personnel. In many police agencies externally hired senior police managers have been actively resisted by the rank and file within police organizations.

These tendencies, to promote long-serving members from within the police organization, naturally lead to organizations characterized by stability and maintaining a status quo approach to issues rather than a progressive, dynamic, change-oriented approach to matters. This may be referred to as organizational stasis, since these organizations tend to resist change, maintaining long-standing practices, policies and procedures.

e. Police Unions

Unions typically advocate for the rights of workers and help to maximize salaries and working conditions for the employees they represent. In the realm of policing in Canada, and particularly in British Columbia, the union representing municipal police officers has been very active in resisting any progressive changes to police oversight and accountability mechanisms.

A proposal to institute “integrity testing” by setting up undercover scenarios in which police officers would be tempted to engage in corrupt practices was strongly criticised by the police union (Smith, 2004). The head of the local Vancouver police union, Tom Stamatakis, argued the police officers responsible for the Stanley Park beatings in 2003 should not lose their jobs (Armstrong, 2004). Stamatakis has also gone on record as opposing the use of polygraphs to determine whether police who are under investigation for alleged wrongdoing are telling the truth (Ferry, 2009).

At a recent public forum on police accountability (Nov. 30, 2009), Tom Stamatakis spoke out against using civilians to investigate serious police wrongdoing. His concern appeared to centre on the misleading claim that only the police are competent to carry out such serious investigations.

Police unions and police associations are a powerful lobby voice, which supplement the police chiefs’ association in exerting pressure on government for what they perceive

to be pro-police policies and laws. It has been noted: “...police unions make themselves heard. Few agencies or offices of government with responsibilities in the policing area do not now consult the local or provincial union. Much weight is placed on a union’s political potential...” (Martin, 1995, p. 139).

f. Police as a Lobby Group

The police constitute a powerful lobby group that seeks to have its interests protected through law and policy. Members of the B.C. Police Association, a group representing municipal police officers throughout B.C., and headed by the President of the Vancouver Police Union, regularly lobby MLAs in Victoria (BCPA, 2009; BCPA, 2010). The police go to great lengths to have their views enshrined in law and policy, influencing federal, provincial and local politicians at every opportunity.

In regard to police resistance to civilian investigation of police wrongdoing, the Ombudsman for Ontario, Andre Marin, has noted:

Police special interest groups, including powerful unions, have succeeded in keeping themselves immune from independent oversight. The lessons learned from Tarnan, Harper and Dziekanski are ignored as police management and unions, normally at loggerheads, come together to fight the common enemy of effective civilian oversight, stampeding politicians in the process. The police lobby at times borders on the hysterical. It’s all about the police maintaining control. Time after time, incident after incident, public outcry after public outcry, they wheel out the same tired old red herrings in an attempt to convince the public that the sky will fall if civilians are allowed to investigate police (Marin, 2009).

One political staffer for a Conservative MP had no qualms in branding the Canadian Associa-

tion of Chiefs of Police a “politically motivated lobby group” (Akin and Tibbets, 2010). Police often get a sympathetic ear in legislatures across the country. Their refrain echoes the law and order politics that appears to curry much favour with politicians in recent years. They frequently call for increased punitiveness in the justice sys-

tem, decreased constitutional protections for accused offenders, and an increased emphasis on victim’s rights (Forcese, 1999). Regarding rigorous oversight and civilian investigation of alleged police wrongdoing, they have been vocal in their opposition to genuine reform that would take the process out of the hands of the police.

Chapter 5

A Model System of Investigation/Oversight

Through past practice, the police have shown they can not be trusted to investigate themselves. Keeping the investigation of police wrongdoing in the hands of the police is no longer a viable option. Bias, whether real or perceived, precludes the idea of the police continuing to have a role in their investigation. Maintaining the credibility of the justice system in the eyes of the community requires this kind of change. An ideal system for dealing with the aftermath of a death in police custody involves, at its core, an independent civilian investigative agency responsible for looking into allegations of wrongdoing by the police. It should be an agency that has the ability to approve criminal charges, which are then prosecuted by independent prosecutors.

The best lessons for developing such a system of investigation is to take the best from those jurisdictions which have been at the forefront in this area, and have shown success. In Canada, this means looking at the SIU model in Ontario since it has the benefit of being Canadian and being in existence for 20 years, and while not perfect, contains many of the elements of an ideal system. It also means looking at the Alberta model (ASIRT) and the Manitoba model (IIU) as two of the newer examples of a reformed approach to investigation of alleged police wrongdoing. However, guidance can also be taken from the experiences developed in the UK, where the Independent Police Complaints Commission (IPCC) for England and Wales and the Police Ombudsman for Northern Ireland (PONI) present themselves as ideal sources from which to garner ideas.

- Open and Transparent – to hold the public trust, any system of police oversight and investigation must be open and transparent. Any reasonable person would find that a fellow police officer is incapable of rendering a fair judgment in assessing the evidence being gathered against a colleague.
- Absence of Bias – to be considered fair, an investigative system must be free from investigator bias, including bias held by the investigator’s supervisor, and the process must be one in which the public has access to the process, and confidence in the fairness of the outcome.
- Independence – the agency and its investigators must be free from interference by government and the police; to this end, the appointment of an agency’s leader must be non-partisan and involve the selection of a person without a police or prosecutorial background, and the investigators should not be police officers or former police officers.
- Universality – the agency should have the power to investigate all police agencies in the province; failure to grant this broad jurisdiction results in either the municipal police or the RCMP being subjected to a second class system of oversight.
- Sufficient Budget – proper police oversight and investigation does not come without a cost; however, the cost of failing to provide a properly structured

and funded system is the ongoing absence of public confidence in the police.

- Sufficient Powers for Investigators – independent investigators should have all the powers of police officers and their authority should take precedence over the police themselves in a scene where the civilian agency has jurisdiction
- Broad Jurisdiction – independent investigators should have the authority to investigate “all” incidents the director of the agency thinks warrant such an investigation; restricting the scope of jurisdiction to death and serious injury/harm leads to confusion over the definition of injury/harm and leaves out many other cases that give rise to a lack of public confidence in the police.
- Off Duty Conduct – the independent agency should always investigate cases within its jurisdictional scope where the allegation of wrongdoing involves a police officer, even if they were not on duty at the time of the incident; it is not the fact that an officer was on duty that gives rise to a need for independent investigation, it is the fact that the alleged wrongdoer is a police officer.
- Post-termination role – police should not be able to escape investigation by an external investigative agency through simply resigning or retiring from their position; if the individual held the office at the time of the alleged incident, they should be subject to the same investigative process as if they remained on the job.
- Independent Prosecutors – Since the police and prosecutors develop close working relationships, it is imperative that independent prosecutors be responsible for determining whether to proceed with

charges against an officer, and to conduct the prosecution; a perception of bias prevails if regular prosecutors are used.

a. Civilian Investigative Agency

An ideal system for dealing with the aftermath of a death in police custody involves, at its core, a civilian investigative agency responsible for investigating allegations of wrongdoing by the police. It should be an agency that is responsible for recommending prosecutions be carried out by independent prosecutors.

Through past practice, the police have shown they can not be trusted to investigate themselves. Keeping the investigation of police wrongdoing in the hands of the police is no longer a viable option. Bias, whether real or perceived, precludes the idea of the police continuing to have a role in their investigation. Maintaining the credibility of the justice system in the eyes of the community requires this kind of change.

Reinventing the wheel is rarely a good idea. Since several jurisdictions have already created independent civilian agencies to investigate alleged police wrongdoing, it makes sense for any jurisdiction contemplating such a change to look to these examples for guidance. Perhaps the best lessons can be learned from looking at the SIU model in Ontario since it has the benefit of being Canadian and being in existence for 20 years. However, guidance can also be taken from the experiences in the UK.

b. Open and Transparent

Any system of police oversight and investigation must be open and transparent if it is to hold the public’s trust. Any reasonable person would find a fellow police officer unable to render a fair judgment in assessing the evidence gathered against a colleague. A system in which fellow officers investigate each other is patently an unfair system. It causes reasonable people to lose confidence in the way in which the system works.

	Supervision of the Agency	Civilian Investigative Staff?	Civilians investigate all death and serious injury cases	Role in non-death/serious injury cases?	Control over initiating investigation?	Independent Prosecution?
Ontario (SIU)	Civilian Director	Yes	Yes	None	Yes	No
Alberta (ASIRT)	Civilian Director	No - police only	No	Yes - if of a serious or sensitive nature	No - requires Ministerial authorization	No
Manitoba (IIU)	Civilian Director	Yes	Yes	Yes - monitor internal investigation and take over if necessary	Yes	Yes
England (IPCC)	Independent Commission	Yes	Yes	May supervise or manage internal police investigations	Yes	No
N. Ireland (PONI)	Independent Ombudsman	Yes	Yes	Yes	Yes	No

Table 1: Comparison of oversight agencies

To be considered fair, an investigative system must be one in which the biases of the investigator are minimized, and the public must have a right to know the fairness of the process used and the end result of that process. The results of an investigation and the decision whether to prosecute should be decisions that are subject to public scrutiny. Only through an open and transparent process can the public be satisfied in the integrity of the process.

c. Independent

Independence and impartiality are as important to investigation as they are to adjudication. Judges must be independent from government in order to be free to render unbiased, impartial decisions. Similarly, the police need to be sufficiently independent from the various branches of government to be free to conduct fair and impartial investiga-

tions that are not subject to government interference (see: Wood and MacAlister, 2005).

In the context of investigating police wrongdoing, the most important aspect of investigative independence is for the investigators to be independent from the police themselves. As with the judicial process itself, investigations need to be impartially carried out, and have the appearance of impartiality: “Not only must justice be done; it must also be seen to be done.”⁵⁶ In order to avoid the appearance of a conflict of interest, investigators should have no prior connection with those being investigated. Where the investigator and the person being investigated share the same occupation, there is an appearance of bias that can never be remedied. As a police officer, the investigator has a conflict of interest. It is in their interest to maintain the public’s perception of the profession in a positive light.

This leads too readily toward decision-making that is potentially tainted by that conflict.

The very nature of the police occupation presents a problem to self-investigation. The police rely on one another for support and backup, leading to a strong internal organization that fosters and promotes a protective mentality. Many police exhibit an “us-against-them” outlook that is manifested through their perceptions of the dangers associated with the job. The close connection that develops among police officers produces the conflict of interest that makes it impossible for us to allow the police to investigate themselves. The working personality and occupational subculture of policing produce the appearance of bias that calls for an independent investigative agency as the only solution to the perception of bias. The perceived bias is incurable through minor tweaking of the self-investigation process. The public will only be confident in the outcome of an investigation of an allegation of police wrongdoing if an entity other than the police is responsible for carrying out the investigation.

A civilian investigation unit should have the power to investigate all police agencies in the jurisdiction. Provinces such as B.C. with both municipal and RCMP police, many of whom are contract police for the province and municipalities, should not be subject to separate accountability regimes. The public expects that all police will be held similarly to account for their actions. Duplication of services makes little sense from a fiscal or a practical standpoint. Also, where two or more schemes exist, one will inevitably come to be seen as inferior to the other. All of this can be avoided by the RCMP subjecting itself to investigation by the agency established by the province for the purposes of investigating alleged police wrongdoing. The RCMP’s commissioner has recently indicated a willingness to have the RCMP investigated in this way.

In February 2010, RCMP Commissioner, William Elliott, announced a new policy which he said would make the organization “as open and transparent as possible” (RCMP, 2010). To that end, he announced that:

The RCMP policy supports and is consistent with broader efforts to provide for investigations to be carried out by independent agencies as is already the case in some provinces and as is being implemented elsewhere. The RCMP supports these initiatives and considers its policy to be an interim step to provide further independence and assurances of impartiality whenever employees of the RCMP are under investigation.

The policy clearly states that the RCMP would prefer never to be called upon to conduct investigations of RCMP employees but recognizes that there are not currently independent agencies in place in all jurisdictions. Wherever such an agency does exist the new policy directs that the RCMP will refer investigations to it.

The RCMP strongly supports independent investigations and enhanced independent oversight and review and looks forward to future initiatives to advance these important goals (RCMP 2010).

For this policy to be effective, all provinces must adopt a civilian investigative agency. Without it, the nation’s RCMP officers will continue to be mostly investigated by other police officers.

d. Sufficient Budget

British Columbia needs to provide sufficient resources to fund an effective investigative agency. Without this, it is not possible to conduct timely, thorough and effective investigations of police wrongdoing. Eliminating the role of the police investigating themselves should free up resources to fund a new investigative agency.

According to annual reports, Ontario's exclusively civilian investigative agency (the SIU) operates on a budget of just under \$7 million per year (SIU web site). Clearly, running an autonomous agency to investigate police wrongdoing is a costly endeavour. However, provinces such as B.C. which do not currently use an autonomous investigative agency have costs as well, although the exact extent of these police-investigating-police costs is unknown, being buried in the budgets of existing police departments. Vancouver currently has 12 officers working in its professional standards (internal affairs) division. The salary costs for this group of officers is not insignificant. Additionally, the Office of the Police Complaint Commissioner in B.C. has an annual budget of just under \$2 million, yet this agency does not carry out routine investigations of police wrongdoing (OPCC web site).

If the resources currently being put into the police officers currently being used to carry out investigations of alleged police wrongdoing was combined with the OPCC budget, the costs of a civilian investigative agency for the province of British Columbia might not be significantly greater than the current expenditures on a system that is not trusted for its results.⁵⁷

e. Powers of the Director and Investigators

Independent investigators should have all of the powers of peace officers. They must have unrestricted access to all evidence in the hands of the police, and access to all witnesses necessary to fully carry out their investigations. The director of the investigative unit must be independent from government and police influence and must have the discretion to refer appropriate cases to an independent prosecutor for charge assessment.

i. Jurisdiction

An important issue regarding the powers of civilian investigators is the scope of their jurisdiction.

It seems incontrovertible that civilian investigators should minimally be investigating all cases of death and serious injury or harm allegedly committed by police officers. Defining the scope of these terms, particularly serious injury/harm has been a point of contention in this area of study. It is also arguable that the scope of investigators' jurisdiction should be even broader.

Granting jurisdiction to a civilian agency to investigate all allegations of police wrongdoing may be unworkable. Minor transgressions such as motor vehicle infractions, regulatory infractions, and the like could possibly be carried out by investigators internal to the police agency. Officers of the police agency involved may be in a better position to assess whether another officer has transgressed rules and regulations pertaining to the standards expected of an officer in his or her daily conduct. However, it is desirable to have as many allegations of impropriety as possible addressed by an external agency if public trust is to be maintained.

Ontario's pioneering legislative reform that led to the creation of the SIU confines their jurisdiction to cases of death and serious injury. Defining serious injury has been an ongoing problem under the legislation. Some jurisdictions grant the external investigating agency the authority to look into additional wrongs such as all incidents of a "serious or sensitive nature" (Alberta), all incidents where the "public interest" necessitates it (British Columbia), or all "criminal offences" (Saskatchewan; Manitoba). Expanding the scope in this way seems highly desirable to avoid the arbitrary distinctions between cases that have produced considerable problems in Ontario.⁵⁸

Off-duty conduct should also be the subject of investigation by an outside agency. Several high profile cases that have led to calls for external investigation in Canada have involved off duty conduct.⁵⁹ The fear of bias

in favour of the officer being investigated arises equally when the conduct in question occurs off-duty as when it occurs on-duty.

Police officers should not be able to escape investigation by an external agency by simply leaving their job behind. Legislation should ensure that the agency retains jurisdiction to continue its investigation after an officer resigns or retires from their police job. Several recent allegations of wrongdoing by the police in B.C. have resulted in investigations being terminated when the officer in question left their job.⁶⁰

ii. Investigative Powers

The civilian investigators must be given sufficient powers to enable them to effectively and efficiently carry out their investigations. If the investigators are dependent on cooperation from the police agencies being investigated, there are likely to be problems. Ontario's experience is illustrative in this regard. If the police agency being investigated makes its own determinations about whether to bring in the external agency, one can assume such investigations will not occur as frequently or as timely as one might expect. If the police being investigated and their colleagues in their department have discretion regarding cooperating with the investigation, one can expect less than full cooperation.

There must be provisions to ensure the civilian agency is brought in for all appropriate cases. Leaving it up to the police agencies themselves to determine whether the circumstances merit external investigation is not an appropriate way to accomplish this. All cases of police wrongdoing should be immediately referred to the external agency, and then the agency itself should determine whether the circumstances bring the case within its mandate. Disagreements between police agencies and the civilian agency over jurisdiction should be resolved through referral to an impartial third party, such as an official within the Attorney General's Ministry. The

legislative framework should make it clear that joint investigations (eg. where the police must also investigate the incident in regard to conduct of non-police officers) should be structured with the civilian agency being given priority.

Investigators must have the freedom to gather necessary evidence, conduct a full and timely investigation, and have the cooperation of the officers in the department being investigated. They should have access to independent labs for the analysis of evidence. A great deal can be gleaned from the recent report of the Ontario Ombudsman that looked into the state of the SIU (Marin, 2008). Any jurisdiction creating a civilian investigative agency should use that report and the recommendations it contains as a template for the construction of a new process.

f. Independent Prosecutors

In all jurisdictions, police and prosecutors develop close working relationships. As a result of this close relationship, a perception of bias arises if the local Crown prosecutors are responsible for determining whether charges should be laid against the police. There is a perception of bias that it is not possible to remedy through various approaches such as having prosecutors from a different region of the province make the determination of whether charges are appropriate.⁶¹

The use of local defence lawyers under contract to make determinations regarding the appropriateness of charges against the police may not sit well with many police officers. There is often no love lost between the police and the local defence bar, which gives rise to concern regarding the potential for bias in the opposite direction from that which may prevail regarding prosecutors (i.e. against the police).

Manitoba's recent amendments which have led to civilian-led investigations in that province addressed this problem by requiring lawyers from outside the province be used to determine

whether charges should proceed against police officers. This seems like a logical answer to the issue, provided such lawyers can get approval to engage in legal practice in the province.

Chapter 6

Preventing Police-Involved Deaths

While society needs to respond effectively and fairly to deaths that occur in police custody, an ideal situation would be one in which no deaths occur in police custody. Accordingly, attention needs to be paid to preventing police-involved deaths.

a. Coroner's Powers and Obligations

One of the main purposes behind coroner's inquests is to identify how deaths can be prevented. Coroner's juries routinely identify various ways in which a death they are charged with looking into could have been averted. Accordingly, the coroner's inquest system provides one way through which preventive approaches can come to be identified. While the coroner system in British Columbia is less than ideal (see Part 1 of this report for a discussion of its problems), it does provide one way through which ideas about prevention can be generated.

Prior to 2010, a coroner was required to conduct an inquest in regard to all deaths arising in police custody. In March 2010, the provincial government put through an amendment to the Coroners Act that took away the mandatory inquest provision for deaths in custody in s. 18, replacing it with a provision that makes it discretionary if the Chief Coroner determines the death was natural and non-preventable or there is no meaningful connection between the death and the nature of the care and supervision provided (or if there is going to be a public inquiry into the death).⁶² Given that so many of B.C.'s past Chief Coroners have been ex-police officers, it is a matter of concern that they are trusted to make the assessment out of hand. The whole idea behind an inquest to determine if the death

was natural, to determine if it was preventable, and to determine if it resulted from the way in which the detainee was treated. This legislative amendment is a cause of major concern.

Local Vancouver lawyer, Cameron Ward, has commented on the new provisions in the B.C. Coroners Act, noting:

A coroner's inquest has often been the only avenue by which a deceased's loved one can learn the truth about what happened... It permits the full airing of the facts. In my view, this legislation reduces transparency, and it concerns me a great deal because it may result in these important cases being obscured and the details being withheld from public view (as quoted in Pablo, 2010).

The opportunity to identify new preventive strategies is greatly reduced by eliminating the need for mandatory inquests in all in-custody death cases.

Access to the findings and recommendations of coroner's juries would be advantageous for future research as well as public awareness of what can be done to reduce the number of police-involved deaths. Beginning in early 2008, the B.C. Coroners Service began placing jury findings on their web site. While this does not provide a complete account of what transpired at coroners' inquests, it partially fills a knowledge gap in this area.

b. Use of Force

The various cases of police-involved deaths that have come to the public's attention in recent years have consistently drawn attention

to problems associated with the use of force.

Police have a duty to enforce the law.⁶³ To aid them in their law enforcement mandate, they have been granted the authority to use force, including lethal force, under s. 25 of the *Criminal Code*:

25. (1) Every one who is required or authorized by law to do anything in the administration or enforcement of the law

- (a) as a private person,
- (b) as a peace officer or public officer,
- (c) in aid of a peace officer or public officer, or
- (d) by virtue of his office,

is, if he acts on reasonable grounds, justified in doing what he is required or authorized to do and in using as much force as is necessary for that purpose.

...

(3) Subject to subsections (4) and (5), a person is not justified for the purposes of subsection (1) in using force that is intended or is likely to cause death or grievous bodily harm unless the person believes on reasonable grounds that it is necessary for the self-preservation of the person or the preservation of any one under that person's protection from death or grievous bodily harm.

(4) A peace officer, and every person lawfully assisting the peace officer, is justified in using force that is intended or is likely to cause death or grievous bodily harm to a person to be arrested, if

(a) the peace officer is proceeding lawfully to arrest, with or without warrant, the person to be arrested;

(b) the offence for which the person is to be arrested is one for which that person may be arrested without warrant;

(c) the person to be arrested takes flight to avoid arrest;

(d) the peace officer or other person using the force believes on reasonable grounds that the force is necessary for the purpose of protecting the peace officer, the person lawfully assisting the peace officer or any other person from imminent or future death or grievous bodily harm; and

(e) the flight cannot be prevented by reasonable means in a less violent manner...

This is a fairly complicated provision. In subsection (1), it creates a legal justification for individuals, including police officers, to use as much force as is necessary in the administration and enforcement of the law provided their actions are required or authorized and they act on reasonable grounds. The section goes on in subsection (3) to limit the type of harm that may be inflicted. It excludes protection where the force used was "intended to or likely to cause death or grievous bodily harm unless the person believes, on reasonable grounds" that force of that nature is required to protect oneself or another under one's protection from death or grievous bodily harm. However, subsection (4) permits the police to use force that is intended or likely to cause death or grievous bodily harm to prevent a suspect from fleeing a lawful arrest, provided the requirements of the provision are met. Those provisions require the arrest to be lawful, the offence must be serious enough that the person could be arrested without warrant, the officer must reasonably believe the force is



Figure 1: Use of force model

necessary to protect the officer or others from “imminent or future death or grievous bodily harm,” and the escape cannot be prevented by “reasonable means in a less violent manner.”

The current state of s. 25 of the *Criminal Code* reflects a restriction on the ability of the police to use deadly force compared to that of years gone by.⁶⁴ In particular, subsection (4) limits the so-called “fleeing felon” rule to use in circumstances where the officer believes on reasonable grounds that deadly force is necessary to protect the officer or others from imminent or future death or serious harm. It is arguable that this restriction does not go far enough. The subsection permits police to

shoot fleeing suspects even where there is no imminent threat to life or safety. That is, they may shoot if they reasonably believe the suspect is a “future” threat. The power to shoot in such circumstances was taken away from American federal law enforcement in 1995 following the investigation into the FBI’s conduct at the Branch Davidian Compound in Waco, Texas and the Ruby Ridge, Idaho incident. The US federal government decided that only “imminent danger” would justify the use of lethal force by federal law enforcement (Hall, 1996).

In addition to the s. 25 provision, the *Criminal Code* grants additional powers to the police to use force. These provisions include using force

to prevent the commission of certain crimes (s. 27), dealing with a breach of the peace (ss. 30 and 31), suppressing a riot (ss. 32 and 33), as well as the use of force in self defence (ss. 34, 35 and 37), defending one under one's protection (s. 37), and in defence of property (ss. 38 – 42).

The various provisions in the *Criminal Code* typically authorize the use of “as much force as is necessary” or a level of force that is “reasonable” in the circumstances. However, this can be problematic for several reasons. First, the provisions, particularly s. 25, generate the impression that it is expected that the police will use force to enforce the law and resolve conflict. Second, the level of force that is appropriate in the circumstances is left rather vague. Determining how much force is “necessary” or “reasonable” is difficult to ascertain. In an effort to clarify the level of force that is appropriate in any given circumstances, the police have adopted a “use of force model” to guide them in addressing such encounters.

The RCMP and municipal police agencies have employed a “use of force” model similar to the one outlined in Figure 1 on page 82 (this is the RCMP's model; the one used by other police agencies may differ slightly):

In this model, the police have attempted to create a standardized approach to conflict situations that may require the application of force. It is based on the notion that some situations will require the use of little or no force to resolve, while others may require a great deal of force. The apparent objective of the model is to guide the police to select a level of force that is appropriate to the circumstances, not too little (for fear of the officer or others being injured) and not too much (for fear of unnecessarily injuring the suspect).

Under this model, police are encouraged to take a graduated or continuum approach to resolving the conflict. The outer areas of the wheel re-

fect the officer's response, while the inner portion of the wheel identifies different situational factors that may be encountered. Starting at the top of the wheel, the police may be able to resolve a situation involving cooperative subjects through their mere presence. Failing this, they may move clockwise around the wheel using communication, both verbal and non-verbal to attempt to resolve a situation and gain control if necessary. If subjects are determined to be passively resistant communication remains an option, but police are prompted to consider using “soft” responses, such as taking hold of the person with their hands, or using arm locks or other physical manipulation. More combative situations may call for more intense responses, including the use of intermediate weaponry such as conducted energy weapons (Tasers), batons, oleoresin capsicum (O.C.) spray. At the upper end of the situational dynamic, officers are given the option to use deadly force, such as firearms or ramming people with their car.

This model is a replacement for earlier use of force models which were generally very linear. Those linear models did not reflect the true nature of most real life situations in that they tended to assume that all situations were uni-directional, going from calm through increasing states of agitation to extreme violence. The reality is that situations may not follow this progression at all. They may be initially extremely violent without any build up. Additionally, other situations may start out fairly intense, but they may ease off with parties becoming co-operative. A uni-directional linear model encourages three things that are not necessarily desirable. First, they may cause a police officer to start out at the low end of the continuum without really appreciating the serious nature of a confrontation. For example, they may be attempting to deal with a situation through their command presence when a suspect is acting violently, causing harm to the officer or others. Officers may be too concerned with try-

ing to pick the lowest response alternative that might not be appropriate in the circumstances. A second problem with a linear model is that it may inhibit an officer from thinking about backing off to a lower level of response even when a situation becomes less volatile. This results in the use of an excessive level of force than is required in the circumstances. The third problem with such a model is that it treats responses as alternatives or options on an escalating scale. Once one moves up the scale, using lower level options appears to be unthinkable. In such cases, once the officer draws a gun, the use of physical presence and tactical communication may not present themselves as options any longer. The current use of force model attempts to remedy these weaknesses; however, some of those problems may persist.

Clearly, the “wheel” or “circular” model attempts to introduce an element of proportionality between the situation and the police response. It attempts to keep the officer aware that he or she may resort to lower level options as the circumstances warrant. It keeps the lower level options always in the picture to be used as a supplement or replacement for higher level options in any given circumstance. It encourages the officer to identify the correct response options to be used immediately in an appropriate circumstance once the situational dynamics have been assessed.

However, there may still be problems with this model that lead to excessive use of force and unnecessary loss of life in some police-citizen encounters. The idea behind the model appears to ensure police remain in control of any given situation, always staying one step ahead of the person with whom they are dealing. Their level of force appears to be a notch up from what they are encountering. An unintended consequence of this may be that the police inadvertently escalate situations into more violent conflicts than they need to be (Stansfield, 1996).

An additional point of contention with the model is trying to ascertain where different police responses fit into the model. For example, is releasing a police dog to bite someone more analogous to the use of an intermediate weapon than the use of deadly force? If so, where does it fit among the intermediate weapon options? Among those intermediate weapon options, where does the use of the conducted energy weapon (Taser) fit? For the past several years, many police officers appear to have been treating it as a response that is near the lower end of the continuum.⁶⁵ Is this appropriate? Given the recent loss of life in the Robert Dziekanski incident, should the Taser not be categorized as a force option just short of firearms?⁶⁶ The use of force model does not provide clear guidance on where various intermediate weapons sit in relation to each other. While flexibility is necessary to deal with the infinitely variable situations police are likely to encounter, the model appears to provide insufficient guidance for decision making that has very serious consequences.

c. Minimizing the Use of Detention

Since many of the individuals who die in police custody die in police cells, minimizing the detention of individuals in police cells should lead to fewer people dying in police custody. In 1972 a legal framework was put in place that sought to minimize the use of pre-trial detention. The *Criminal Code* was amended in that year to create alternative ways of securing people’s attendance at trial without being held in custody until their court date. Police were encouraged to use alternatives to arrest, and to release those who were arrested as soon as possible. The most serious cases still resulted in individuals being arrested and held by the police for a judicial interim release hearing; however, these hearings were expedited in most cases. Currently, we have a regime in which the vast majority of accused people are either brought

to trial through an appearance notice, or they are released shortly after their arrest on a promise to appear or other form of process that avoids lengthy pre-trial detention. However, there has been a recent call for increased use of pre-trial detention, particularly with regard to young people. Additionally, government statistics reveal that an increasing number of people are being held in custody pending their trial.

In January, 2010, the federal government announced that it was going to amend the Youth Criminal Justice legislation to facilitate keeping more young people in custody while awaiting trial (Department of Justice, 2010). While the details of this change have yet to be released, it is a matter of some concern that an increased number of young people are going to be detained in custody pending their trial. The most recent government statistics indicate the number of youth remanded into custody already increased in 2007/2008 from the previous year, showing a 1% increase in that period (Kong, 2009). The most recent statistics on adult admissions reveal a similar 1% increase in the number of individuals remanded into custody pending trial in 2006/2007 over the previous year (Babooram, 2008). Compared to the previous decade, 26% more individuals are remanded into custody (Babooram, 2008). Given the increased likelihood of bail being denied, it is not inconceivable that police will be increasingly likely to arrest and detain individuals for bail hearings.

It is arguable that fewer people should be held in pre-trial detention, not more. Individuals held in remand are individuals who have not yet been tried and are accordingly presumed innocent. The recent proposals to deny bail more often to young people, and the data which reflects increasing use of custodial remand for all ages of offenders lead to an increased concern over the potential for deaths in custody. The more people who are held in police custody, the greater the number we can expect to see die in that context.

d. Alternatives to Detention

Police holding cells typically hold two groups of people. One group are individuals who have been arrested by the police, either on a warrant or as a result of the police exercising their warrantless arrest powers. This group are held while they are processed. Processing may involve the individual being released by the officer in charge of the police department, or it may involve detention until the person is brought before a justice for a judicial interim release (bail) hearing. These hearings almost invariably occur within a day of the individual being arrested. If the individual is denied bail, they are typically sent to a provincially run remand facility, out of the control of the police. The other major group of individuals held in police lock-up facilities are those who have been arrested for being found intoxicated in a public place. In B.C., the *Liquor Control and Licensing Act*⁶⁷ provides:

- 41 (1) A person who is intoxicated must not be or remain in a public place.
- (2) A peace officer may arrest, without a warrant, a person found intoxicated in a public place.

Individuals arrested under this power are typically held until the following morning when they are released, usually without being charged.

Individuals detained by the police for being intoxicated in public are at a high risk to die in custody. They sometimes aspirate on their vomit and asphyxiate, or succumb to acute alcohol poisoning. Vancouver City has a Detox Centre sobering unit which takes in some intoxicated individuals who have been arrested by the police;⁶⁸ however, not all jurisdictions have such a unit, and even in Vancouver, not all intoxicated arrestees are taken to the unit. Many intoxicated individuals continue to be detained in police cells in the City. Some of these highly in-

toxicated individuals also commit suicide while in police cells. Finding an alternative way of dealing with these individuals may provide the greatest promise for decreasing the number of individuals who die in police custody each year.

The Davies Commission that investigated the death of Frank Paul addressed this matter in some detail. Among the most salient recommendations made by the commission are those dealing with intoxicated subjects. The commission recommended that Vancouver move to a civilian-run program for chronic alcoholics, taking the issue out of the hands of the police (Davies, 2009, p. 197).

e. Conditions of Detention

Individuals who are taken into custodial facilities by the police are at a significant risk for death or serious injury. Some effort has been expended in recent years to try to reduce the number of deaths that occur in police custodial facilities. However, additional preventive measures should be put in place in an effort to further reduce the number of deaths arising in this context.

Individuals who are brought into police custody experience a very high level of distress, particularly during the initial period of detention. This has been associated with increased likelihood of suicide. Recent years have seen such positive developments as the redesign of prison cells to minimize the hanging points that have historically been associated with suicides in police cells. The police-sponsored Canadian Police Research Centre released a report in 2000 recommending modifications to police holding cells in order to reduce aggressive and self-destructive behaviour of those being detained (Krames and Flett, 2005). The report, *Jail/Holding Cell Design*, listed a broad range of changes to police holding cell design and regimes. Among the most important recommendations were those calling for a redesign of cells to eliminate hanging points, the use of

suicide-proof blankets, and the installation of closed-circuit television equipment in all police agencies. Other recommendations included setting national standards, improved training, the creation of standardized reporting practices, and the adoption of a suicide screening device.

i. Health Screening

Individuals taken into police custody frequently suffer from a wide range of physical health problems, mental health problems, and problems associated with alcohol and drug abuse. While it is impractical to expect police detention facilities to have a medical doctor on staff full-time to assess all incoming detainees, the duty that is owed to detainees requires proper assessment at lock-ups.

A study recently conducted in London, England, found that more than one half of individuals detained in a police lock-up had medical conditions:

7.1% had previously been sectioned under the Mental Health Act 1983; 16.7% had previously intentionally self-injured; 33.9% were dependent on heroin, 33.9% on crack cocaine; 25% on alcohol, 16.6% on benzodiazepines and 63.1% on cigarettes. 56% of subjects had active medical conditions; of those with active medical conditions 74% were prescribed medication for those medical conditions; only 3/70 had their medication available. 28/70 were not taking medication regularly, and many were not taking it at all. Three subjects who had deep vein thromboses were not taking their prescribed anticoagulants and six subjects with severe mental health issues were not taking their anti-psychotic medication. Mental health issues and depression predominated, but there was a very large range of mixed diseases and pathology. Asthma, epilepsy, diabetes, deep vein thrombosis, pulmonary embolism, hepatitis, and hypertension were all represented (Payne-James, et al., 2010, p. 11).

These give cause for concern to those interested in preventing police-involved deaths. In order to ensure those individuals with the greatest health care needs are diverted out of police custody and into the health-care system, proper screening is required.

In a recent study, also carried out in London, England, researchers found well-trained booking sergeants could detect a wide range of physical health problems which were properly referred to a physician for a fuller assessment; however, they were less adept than physicians at identifying psychiatric disturbance, particularly depression and a history of self-harm (McKinnon and Grubin, 2010). Clearly, there is a need for extensive training and statutorily mandated referral to a physician if there is any question regarding the physical or mental health status of an individual being brought into detention.

f. Advisory Panel on Deaths in Custody

In order to increase attention to the deaths in custody and to provide alternatives to the present way of doing things, it is desirable for Canada to develop an advisory panel on deaths in custody. The federal prison ombudsman has recently called for such a forum (Sapers, 2010); indeed, he has begun the ground work of bringing together a group of concerned professionals to deal with the matter. How-

ever, the initiative would have a greater likelihood of making positive contributions if it was supported by government resources. This would show both a genuine concern with the issue, as well as enable the panel to have a significant impact on policy development.

In the United Kingdom, a Forum on Preventing Deaths in Custody was created through legislation in 2005.⁶⁹ The forum was an independent group that sought to identify best practices to reduce deaths in custody. Following a governmental review, published in 2008, the forum was disbanded and replaced by the current Independent Advisory Panel on Deaths in Custody. That panel, which came into being in early 2009, now provides advice to the Ministerial Board on Deaths in Custody which is headed by the Justice Minister.⁷⁰

The proposal forwarded by the federal Correctional Investigator to establish and maintain a forum or advisory panel on deaths in custody should be supported by both levels of government. Many deaths in custody are preventable. An advisory panel would develop increased awareness of this issue and provide a venue through which best practices and policy improvements could be identified in order to address this concern.

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ENDNOTES

- 1 The civil law of negligence has clearly established a duty of care on the police regarding individuals taken into custody. See, for example, *R. v. Nixon* (1990), 47 B.C.L.R. (2d) 222 (C.A.), *Smith v. B.C. (A.G.)* (1988), 30 B.C.L.R. (2d) 356 (C.A.) and *Funk v. Clapp* (1986), 35 B.C.L.R. (2d) 222 (C.A.).
- 2 *Reeves v. Commissioner of Police of the Metropolis*, [1998] 2 All E.R. 381 (C.A.). While this is an English case, there is no reason to believe a Canadian court would rule any differently on the matter. The B.C. Court of Appeal in *Funk v. Clapp*, *supra* note 1, failed to find the police at fault, but did accept the principle that the police owe a duty to a detainee to exercise reasonable care to protect the individual from a foreseeable risk of suicide.
- 3 Numerous cases have supported this proposition, including the B.C. cases of *Lipcsei v. Central Saanich (District)* (1994), 8 B.C.L.R. (3d) 325 (S.C.) and *Fortey v. Canada (AG)* (1997), 45 B.C.L.R. (3d) 264 (S.C.), *aff'd* (1999), B.C.L.R. (3d) 185 (C.A.).
- 4 See: *Armsworthy v. Vancouver (City)*, [1989] B.C.J. No. 707 (S.C.), *Baillargeon v. Clemons*, [1996] B.C.J. No. 827 (C.A.) and *Kirby v. B.C. (A.G.)* (1997), 41 B.C.L.R. (3d) 45 (S.C.).
- 5 Death in Custody Reporting Act of 2000. H.R. 1800, 106th Congress, 1999-2000. See: <http://www.govtrack.us/congress/bill.xpd?bill=h106-1800> Efforts to increase reporting accountability have met defeat in subsequent sittings of the US Congress. A current Bill to increase reporting requirements is currently before the US House of Representatives as H.R. 738, the Death in Custody Reporting Act of 2009. See: <http://www.gop.gov/bill/111/1/hr738>
- 6 *Police Complaint Act 2002*, (U.K.) 2002 c. 30.
- 7 Various coroners/medical examiners have their own web page. See, for example: British Columbia: <http://www.pssg.gov.bc.ca/coroners/>; Alberta: <http://www.justice.gov.ab.ca/ocme/>; Saskatchewan: <http://www.justice.gov.sk.ca/officeofthechiefcoroner>
- 8 See, for example, *Coroners Act*, SBC 2007, c. 15 (http://www.bc.laws.ca/Recon/document/freeside/--%20C%20--/Coroners%20Act%20%20SBC%202007%20%20c.%2015/00_07015_01.xml); *Fatal Inquiries Act*, RSA 2000, c. F-9 (http://www.qp.alberta.ca/574.cfm?page=F09.cfm&leg_type=Acts&isbncln=077973999X); *Coroners Act*, SS 1999, c. C-38.01 (<http://www.qp.gov.sk.ca/index.cfm?fuseaction=publications.details&p=435>) [to be completed]
- 9 For example, British Columbia and Saskatchewan.
- 10 For example, Alberta.
- 11 An access to information request was made of all jurisdictions in Canada seeking summary data and detailed data pertaining to all police in-custody deaths. Detailed information was received from Ontario, while summary data was received from the Yukon Territory, the Northwest Territories, British Columbia, New Brunswick, Nova Scotia and Saskatchewan. The other provinces failed to provide any of the requested data.
- 12 Governed by the *Police Act*, RSBC 1996, c. 367.
- 13 Governed by the *RCMP Act*, RSC 1985, c. R-10.

- 14 On March 31, 2010, new provisions in the B.C. *Police Act* dealing with the investigation of serious wrongdoing came into force. These now require the investigation to be carried out by officers from a different police agency.
- 15 The RCMP has recently begun to use outside agencies to investigate police-involved deaths, as reflected in the recent investigation of a death following a young man's detention in RCMP cells in Whistler, B.C.(Fraser and Bermingham, 2010).
- 16 See s. 3 of the B.C. *Police Act*, SBC 1996, c. 367.
- 17 *Royal Canadian Mounted Police Act*, RSC 1985, c. R-10.
- 18 See *A.G. Alta. v. Putnam*, [1981] 2 SCR 267.
- 19 See *A.G. Que. and Keable v. A.G. Can.*, [1979] 1 SCR 218.
- 20 In April 2010, BC appointed Dr. Diane Rethon, a medical doctor, as Chief Coroner, breaking with a 29 year tradition of appointing former police officers as the Chief Coroner of the province (Shaw, 2010).
- 21 *Police Reform Act 2002*, (U.K.), 2002, c. 30.
- 22 *Police Reform Act 2002*, s. 10.
- 23 See *The Police (Complaints and Misconduct) Regulations 2004*, which require such allegations to be reported to the IPCC. Since IPCC investigative resources are limited, only the most serious allegations are investigated by their own team of investigators (Ormerod and Roberts, 2003).
- 24 *Police Act (Northern Ireland) 1998*, (U.K.), 1998, c. 32.
- 25 Remarkably, a recent commission of inquiry carried out in New Zealand that looked into allegations of sexual assaults involving the police, and concerns over the adequacy of the investigations in those cases, failed to entertain the notion of civilian investigation of such acts. See: Commission of Inquiry into Police Conduct (2007).
- 26 *Police (Complaints and Disciplinary Proceedings) Act 1985*, (S.A.).
- 27 Other Australian jurisdictions appear to employ this “oversight” model as well. See, for example, the New South Wales Ombudsman’s web site. A recent report in that jurisdiction failed to entertain the notion of employing a civilian investigative agency, opting instead to recommend centralization of the investigation of all serious allegations of wrongdoing in a Professional Standards Command, composed of serving police officers (Committee on the Office of the Ombudsman and the Police Integrity Commission, 2006).
- 28 Ontario *Police Services Act*, R.S.O. 1990, c. P.15.
- 29 Alberta *Police Act*, RSA 2000, c. P-17.
- 30 The Government of Alberta web site indicates there are currently 105 sheriffs patrolling Alberta’s highways conducting traffic enforcement.
- 31 The statutory framework for the Public Complaints Commission is set out in Part IV of the Saskatchewan *Police Act, 1990*, S.S. 1990-91, c. P-15.01 as am.

- 32 In February 2010, Commissioner Elliott announced cases of serious injury or death involving a member of the RCMP will be investigated by a provincial regime if one exists in the province where the incident arose. Failing this, an external police agency will be called upon to conduct the investigation (RCMP, 2010).
- 33 *Police Act 1990*, s. 91.1(1).
- 34 *The Police Services Act*, S.M. 2009, c. 32.
- 35 For a discussion of the application of oversight to off-duty conduct in Canada, see: Paul Ceysens Off-Duty Police Conduct: A Discussion Paper (2000).
- 36 For example, in 2009 a newspaper delivery man was assaulted by several off-duty police officers in Vancouver (CBC News, 2009b), and Benjamin Monty Robinson, one of the RCMP officers involved in the Dziekanski taser-death incident was involved in an off-duty drinking and driving incident that resulted in the death of a motorcyclist (CBC News, 2009c).
- 37 Personal communication, April 8, 2010.
- 38 *Police Act*, RSBC, c. 367, s. 50.
- 39 *Police (Misconduct, Complaints, Investigations, Discipline and Proceedings) Amendment Act, 2009*. Bill 7, 2009. In force, March 31, 2010. This Bill adds a new Part 11 to the *Police Act*.
- 40 *Police Act*, s. 89(2). The police complaint commissioner must order the investigation be carried out by an external police force or a special provincial constable appointed for that purpose (there are no special constables appointed for this purpose).
- 41 s. 92(1).
- 42 s. 92(2).
- 43 s. 93(1).
- 44 s. 89 (4)(a).
- 45 s. 96. For this purpose, the police complaint commissioner may designate an employee to conduct the observation and report to the police complaint commissioner.
- 46 s. 97(1)(a) and (b).
- 47 s. 97(1)(c) and (d).
- 48 s. 97(3). The chief is responsible for ensuring such directions are fulfilled: s. 97(4).
- 49 ss. 100 - 103.
- 50 s. 101. Other officers are also under a duty to cooperate with the complaint commissioner when exercising powers and duties under the *Police Act*: s. 178.
- 51 s. 106.

- 52 Municipal police in B.C. currently train together in mixed classes at the Justice Institute of British Columbia. Additionally, there are numerous joint task forces which promote considerable cross-jurisdictional contact among B.C. police officers, particularly in the Lower Mainland and Greater Victoria regions. It is also noteworthy that the chiefs of police in Vancouver and Abbotsford, and until recently, the Public Safety Minister/Solicitor General for the province, are all former underlings of the Victoria Police Department's chief, having worked together in Vancouver.
- 53 The *Act* defines serious harm as: injury that (a) may result in death, (b) may cause serious disfigurement, or (c) may cause substantial loss or impairment of mobility of the body as a whole or of the function of any limb or organ (s. 76).
- 54 In late March, 2010, the Chief of Victoria's Police Department requested Vancouver police conduct an investigation into allegations of abuse by a Victoria police officer. The chief selected Vancouver to conduct the investigation, a department headed by the Victoria chief's former underling when he worked in Vancouver as its chief.
- 55 However, this number may have been calculated based on the total number of complaints filed rather than the number of investigated complaints used in later calculations.
- 56 *R. v. Sussex Justice, Ex parte McCarthy*, [1924] 1 K.B. 256.
- 57 There are currently just under 8,500 police officers in British Columbia, just over 2,500 of whom are municipal police officers (the remainder are with the RCMP, either federal or under contract for the province or municipalities). This compares to just over 25,000 police officers in Ontario, only 1,300 of whom are with the RCMP (Statistics Canada, 2009).
- 58 See discussion at pp. 19-22 of Marin's report on the SIU (Marin, 2008).
- 59 The January 2009 incident in Vancouver, B.C. involving the assault of a delivery man by off-duty officers from various Lower Mainland departments, and the 2005 off-duty impaired driving causing death incident in Manitoba that resulted in the Taman Inquiry are prime examples.
- 60 Vancouver Police Chief Jamie Graham left his position while being investigated for failing to cooperate with investigations into 50 allegations of wrongdoing by members of his force. This resulted in the termination of any proceedings against him, despite a ruling by the Police Complaint Commissioner that he had engaged in "discreditable conduct." Similarly, the Police Complaint Commission terminated an investigation of Kash Heed for conduct committed while he was Chief of the West Vancouver Police Department. Heed left the police agency amid allegations that he had improperly informed a police board member of an impending arrest of an individual on child pornography charges. Those allegations were not the subject of a full investigation by the Complaint Commission, possibly due to his departure from the force. Also in West Vancouver, two senior officers went on extended sick leave while under investigation, resulting in disciplinary hearings against them being repeatedly postponed. The eventual retirement of these officers led the Complaint Commissioner to terminate hearings in regard to their conduct in early 2009.
- 61 In British Columbia, Stan Lowe, while working as a Crown Prosecutor, reviewed the evidence gathered in the Dziekanski incident, including the videotape that produced public outrage, yet found that charges against the officers involved did not meet the standard for prosecution. This decision is difficult to comprehend and contributes to concerns regarding the use of provincial

Crown Counsel in making determinations regarding the appropriateness of charges in police-involved incidents.

- 62 This was brought in as part of the *Miscellaneous Statutes Amendment Act, 2010* (Bill 4), s. 31.
- 63 This duty arises at common law and is also set out in legislation in most provinces (except B.C.). See: *R. v. Bonnycastle* (1969), 68 W.W.R. 407 (B.C. C.A.). RCMP derive their duties from the common law and also from the R.C.M.P. Act (s. 18) which requires, among other things, that they engage in the "...apprehension of criminals and offenders...". See: *R. v. L.S.L.* (1991), 89 Sask. R. 267 (Q.B.).
- 64 The restriction imposed by subsection (4) was introduced into our *Criminal Code* in 1994, reflecting similar restrictions imposed on American police in the U.S. Supreme Court's landmark cases of *Tennessee v. Garner*, 471 U.S. 1 (1985) and *Graham v. Connor*, 490 U.S. 386 (1988). Prior to this, Canadian police had wider discretion to shoot fleeing felons. The amendment to the *Criminal Code* also followed closely on the heels of the decision in *R. v. Lines*, [1993] O.J. No. 3284 (Q.L.) (Gen. Div.). See discussion in Scott (2008).
- 65 In the Dziekanski incident, it appears to have been an option that was resorted to immediately after communication was briefly attempted, even before considering empty hand manipulation techniques.
- 66 This appears to be the implication of the new RCMP policy on CEW use announced in 2010 (CBC News, 2010). The RCMP are now limited to using Tasers in situations where a person is causing bodily harm or the officers has reasonable grounds to believe a person will imminently harm someone.
- 67 *Liquor Control and Licensing Act*, RSBC 1996, c. 267.
- 68 The sobering unit holds intoxicated individuals for a few hours and monitors them until they are assessed as able to be released.
- 69 The Forum was composed of senior representatives from the Police Complaints Commission, the Association of Chiefs of Police, the Coroner's Society, the Department of Health, the Prison Ombudsman, the Inspectorate of Prisons, the Home Office, the Inspectorate of Constabulary, the Mental Health Commission, the NGO INQUEST, and other relevant agencies.
- 70 The Ministerial Board brings together decision makers responsible for developing policy related to death in custody issues for the Home Office, the Department of Justice, and the Department of Health.

This report focuses on deaths in actual police custody. When the police take individuals under their charge, they are required to provide them with an adequate level of care.

This report seeks to gain a better understanding of police-involved deaths, and to provide specific recommendations to address how to prevent these incidents from arising, and how to best address investigations into these deaths. Furthermore, it sets out a model of investigation and oversight that ensures a sufficient degree of accountability will be obtained.



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