Alone and Cold

THE DAVIES COMMISSION

Inquiry into the death of Frank Paul

ALONE

AND

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THE DAVIES COMMISSION
INQUIRY INTO THE DEATH OF
FRANK PAUL

INTERIM REPORT
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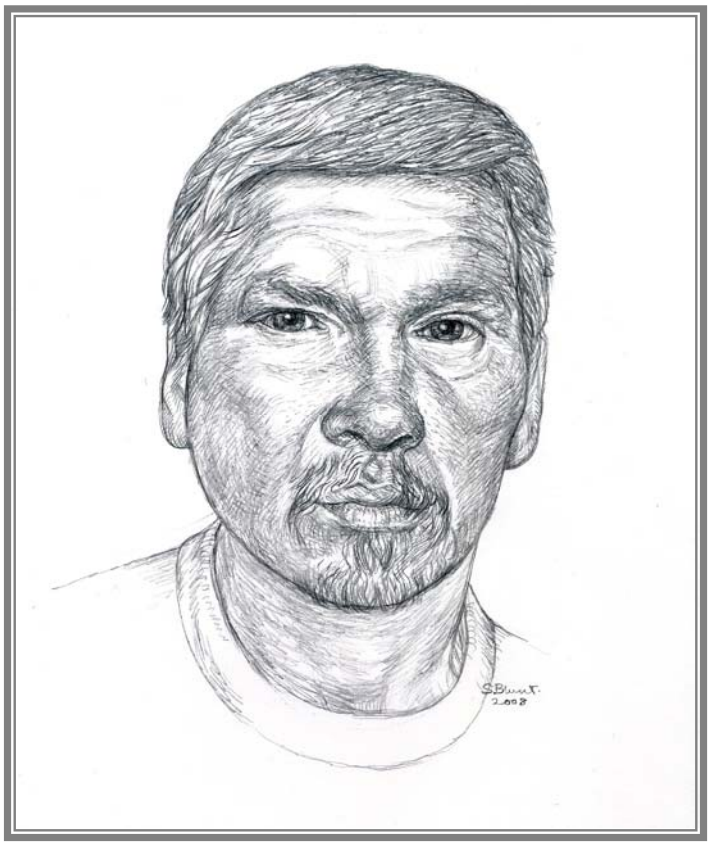

FRANK JOSEPH PAUL

Born: July 21, 1951, Big Cove (now Elsipogtog), New Brunswick

Died: December 5 or 6, 1998, Vancouver, British Columbia

THE DAVIES COMMISSION

William H. Davies, Q.C., Commissioner

February 12, 2009

The Honourable Wallace T. Oppal, Q.C.
Attorney General of British Columbia
Room 234, Parliament Building
PO Box 9044 Stn Prov Govt
Victoria, BC V8W 9E2

Dear Mr. Attorney:

Interim Report of The Davies Commission

I am pleased to deliver this Interim Report to you, as provided for in section 27 of the *Public Inquiry Act*, S.B.C. 2007, c. 9.

In this Interim Report I am addressing all matters set out in the Terms of Reference dated August 10, 2007, except those relating to the Criminal Justice Branch of the Ministry of Attorney General.

As I discuss in more detail in this Interim Report, the Ministry commenced legal proceedings challenging my jurisdiction to inquire into its activities in the Frank Paul matter. For that reason, I have made no inquiries into the Branch's activities pending the outcome of that legal challenge. Depending on the outcome of those proceedings, I may prepare a Final Report dealing exclusively with the Criminal Justice Branch.

Yours very truly,

William H. Davies, Q.C.

D. Geoffrey Cowper, Q.C., Commission Counsel
Brock Martland, Associate Commission Counsel
Keith R. Hamilton, Research Counsel

1040–885 West Georgia St.
Box 1001,
Vancouver, BC V6C 3E8

Tel: (604) 660-6880
Fax: (604) 660-1110

www.frankpaulinquiry.ca

ACKNOWLEDGEMENTS

Commissioner

William H. Davies, Q.C.

Counsel

D. Geoffrey Cowper, Q.C., *Commission Counsel*
Brock Martland, *Associate Commission Counsel*
Keith R. Hamilton, *Policy Counsel*
Keri Gammon, *Assistant Counsel*

Consultant Counsel

Ardith Walkem

Research Consultants

Dr. John Butt
Vernon J.F. Campbell
Dr. Clifford Chan-Yan
Dr. James Alexander Johnston (Rex) Ferris
Dr. Shabehram Lohrasbe
Donald MacPherson
Douglas Nash
Glenn Woods

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FRANK JOSEPH PAUL—A BIOGRAPHY

Much of this report will be about the activities of officers of the Vancouver Police Department (VPD) and of other public bodies, and will examine their policies and practices, especially as they relate to homeless chronic alcoholics.

As I examine these important matters, I ask you to keep in mind that at a more personal level this is a story about one man's life and untimely death.

Many more people have come to know Frank Paul in his death than knew him during his life. The public interest surrounding this inquiry's work put his photo on the front pages of newspapers, and on television screens. While this exposure serves the public interest in raising the profile of important social policy issues, it comes with a risk that when we see Frank Paul's photo we will think "homeless chronic alcoholic," and fail to see the man behind the photo.

Who was Frank Paul? The sad truth is that, even now, we know very little about Frank Paul—his hopes and dreams, his talents, and the traumatizing experiences that led eventually to his living rough on the harsh streets of Vancouver.

During our evidentiary hearings, Frank's cousin, Peggy Clement, and his sister, Frances Jourdain, provided some insights into Frank's life. I have used their testimony, as well as records compiled by the inquiry, to prepare the following short biography.

1. His early life

Frank Paul was born on July 21, 1951, in Big Cove (now Elsipogtog), New Brunswick, a small Mi'kmaq reserve community. His cousin Peggy Clement testified[1] that Frank had

[1] Transcript, Nov. 13, 2007, pp. 75–94.

two brothers (Andrew and Mark) and one sister (Frances). The only one alive today is Frances.

Frank's father, Joseph Henry Paul, had served in the Army during the Second World War. When he came home, he drank heavily. Frank's parents separated when Frank was young and his mother moved to the United States, where she later remarried and gave birth to three boys. Because of his father's excessive drinking, Frank, along with his brother Andrew and his sister Frances, were sent to a residential school in Nova Scotia. They attended the school for four or five years, until it closed down.

Ms. Clement said that when Frank, Andrew and Frances returned to Big Cove from the residential school, Frank was very quiet. By then his father had a new girlfriend. Frank wanted to see his father, but the girlfriend would not allow it. Frank stayed with Ms. Clement's family or with his father's family, moving around quite a bit. He began drinking by age 16 or 17. He had no interest in attending school after his experiences at the residential school, and before long he left Big Cove. He traveled to Maine to pick potatoes, as the family had done when he was younger.

2. His itinerant life

Ms. Clement testified that Frank moved around a lot in Canada and the United States, living as a migrant worker. From official records, we know that he was in New Brunswick in 1974, in British Columbia (Kamloops and Grand Forks) in 1978, in Toronto and Brandon, Manitoba, in 1981, and in Victoria in 1982. Official records indicate that Frank lived primarily in Vancouver from the early 1980s until his death in 1998.

Frank's sister Frances Jourdain, who lives in the eastern United States, testified[2] that Frank would sometimes phone her, or show up unexpectedly at her home and stay with her for several days, then move on. He traveled back and forth across the country by hitchhiking. She said that Frank was a good brother, was happy, and liked what he was doing with his life. He was never drinking when she saw him. His favourite thing to do was draw on canvas.

Ms. Jourdain testified that Frank moved to the West Coast in the 1980s. On one occasion in 1986 he called her to see how she and her family were doing. She told him that their brother Andrew had recently died. A month later he called again, and she had to tell him

[2] Transcript, Feb. 26, 2008, pp. 64–66.

that her daughter had passed away. Frank did not say anything, and just hung up. She never heard from Frank again.

Ms. Clement said that in 1993 she received a phone call from a hostel in Vancouver, saying that Frank was staying there. However, by the time Frank's sister Frances phoned back, Frank had left.

The family heard nothing more about Frank until early 1999, when they were notified of his death in Vancouver. The family made arrangements to have Frank's body returned to New Brunswick for a funeral in the community.

3. His medical condition

My Terms of Reference did not mandate an inquiry into the medical system's treatment of Frank Paul's various injuries and illnesses. Nevertheless, his medical condition became relevant because there was evidence that the response of other public bodies may have been influenced by their lack of understanding or knowledge of his medical state. In particular, on December 5, 1998, the Vancouver Police Jail (Jail) sergeant said that Frank Paul was suffering from a condition that made him appear drunk, when he was in fact sober.

Several other witnesses testified that Frank Paul was a powerful man; seemingly at odds with his reported inability to walk with a regular and reliable gait, frequently taking support from buildings and other props to make his way around. The evidence also disclosed that Frank Paul had suffered grand mal seizures on the street and, when his body was discovered, there was evidence his body had made a "snow angel" from the gravel he was lying upon—suggestive of him suffering seizures before or at the time of his death.

Medical evidence added to my understanding. I heard from Dr. Laurel Gray, the pathologist who performed the autopsy on Frank Paul, and from Dr. John Butt, another well-known pathologist. At my request and with the consent of the Paul family, the Vancouver General Hospital provided 2,024 pages of Frank Paul's medical records, covering the 16-year period from November 1982 to September 1998. The inquiry retained Dr. Clifford Chan-Yan, from the University of British Columbia's Department of Medicine, Division of Nephrology, to conduct a mortality clinic case review. While we could not obtain the records from St. Paul's Hospital, the Vancouver General Hospital

records permitted a fairly thorough review of Frank Paul's medical history. Some of Dr. Chan-Yan's conclusions are as follows:

- Frank Paul had 93 encounters at Vancouver General Hospital, of which:
    - 82 encounters were in the emergency room or observation area, lasting for less than 24 hours, and
    - 11 encounters were longer stays in the observation area or admission to a hospital ward, lasting between 2 and 27 days.
- On 45 occasions, the admission was because of Mr. Paul's seizure disorder. The seizures could probably be attributed to several factors, including alcohol-induced, alcohol withdrawal or past traumatic brain injury.
- On 14 occasions, a main reason for admission to the emergency room was some form of trauma, usually a minor injury occurring as a result of accidental falls, assault or being hit by a car. One injury resulted in surgery for leg and elbow fractures.
- In 1998 he was thought to have developed Wernicke-Korsakoff Syndrome, a condition of alcohol dementia and incoordination of body movement that can be fatal.

Wernicke-Korsakoff Syndrome likely explained Mr. Paul's gait and weakness below the waist, while he still demonstrated strength in his upper body. The psychiatric consequences of that condition support the conclusion that his homelessness was accompanied with a history of mental illness of uncertain duration. I will discuss this later, when considering Dr. Butt's evidence.

4. His extraordinary use of medical and police services

Official records reveal that Frank Paul required a large number of medical and police interventions in Vancouver during his later years:

- He was taken into custody by the VPD on more than a dozen occasions in the months leading up to his death.
- The BC Ambulance Service responded to 121 calls between April 1996 and December 1998.
- He was treated at, or admitted to, Vancouver General Hospital 93 times.

- He was treated at, or admitted to, St. Paul's Hospital 63 times by June 1997 (according to a notation on a BC Ambulance Service form dated June 14, 1997).[3]

- He had been to the Vancouver Detox Centre (Detox Centre) 82 times since 1983.

The professional responders working in the Downtown Eastside knew Frank Paul well. Almost all those who dealt with him in the last days of his life had dealt with him before. He had been, for at least 15 years, part of a small core of homeless chronic alcoholics of less than 100 people. Most of these people are men, and many of them are of First Nations descent.

One police officer witness recalled that during his training as a new officer, he was taken to a call where Mr. Paul was sitting on a sidewalk at a gas station; the field trainer told him he should expect to deal with Mr. Paul a number of times in his career.[4] Ambulance personnel working in Vancouver were not surprised to encounter Mr. Paul, and developed strategies to obtain his cooperation.[5]

Frank Paul did not respond well to persons in authority, and clearly had issues with police officers in general. When he did not react to the uniform, he was cooperative and compliant with those helping him. The Detox Centre sobering unit had a very low tolerance for troublesome behaviour, but afforded him shelter dozens of times, with only one documented example of his behaviour requiring the police to attend.[6]

[3] The Commission of Inquiry requested the hospital records for Frank Paul from St. Paul's Hospital in downtown Vancouver, but St. Paul's could not locate them.
[4] Evidence of Cst. Instant, Transcript, Jan. 9, 2008, pp. 173–74.
[5] Evidence of J. Douglas, Transcript, Nov. 16, 2007, pp. 81–82; evidence of M. Oberg, Transcript, Nov. 22, 2007, pp. 8–11; evidence of F. Grossling, Transcript, Nov. 23, 2007, pp. 38–40.
[6] Exhibit 30 (Detox Centre cardex entries); see also evidence of J. Collens, Transcript, Nov. 27, 2007, pp. 94–97, 110 and 114.

PART 1—OVERVIEW AND EXECUTIVE SUMMARY

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Interim Report of the Davies Commission of Inquiry into the death of Frank Paul

A. Overview

Frank Paul died alone and cold in a back alley in Vancouver sometime on December 5–6, 1998. He had been turned away from the Jail[7] without reason, was not given the choice of staying in the sobering unit of the Detox Centre where he had stayed just the night before, and was left wet and exposed to the elements. He was severely intoxicated, could not care for himself and, in a weakened state, died of hypothermia.

These facts were known or suspected before the establishment of this inquiry and this report confirms the truth of these essential facts. With the help of the voluminous material produced and the many witnesses who testified, we are now able to know far more about the tragic and unsettling final chapter of Frank Paul's difficult and troubled life in Vancouver.

The VPD acknowledged at the beginning of this commission that the two police officers primarily involved made fundamental mistakes of judgement in rejecting Frank Paul from the Jail and leaving him alone and cold in that back alley. My Terms of Reference require, however, that I also conduct a broad inquiry into the institutions that had responsibility to respond to both the circumstances and the possible responsibility for his death.

As to these institutional questions, very little was known prior to the work of this commission. The evidence requires me to conclude that despite the service of many fine and diligent professionals, our systems of justice and social service ultimately failed Frank Paul.

The VPD made an apology in 2004 for its members' role in Frank Paul's death and in the course of this commission its officers acknowledged the errors that were made on December 5, as well as the shortcomings in the subsequent investigation carried out by its Homicide Squad. This report deals extensively with the ways in which that investigation was flawed by reason of inadequate policies and conflicts of interest inherent in police officers investigating fellow police officers for possible criminal conduct.

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[7] "Jail" is used throughout this document to refer to the Vancouver Jail Cell operated by the VPD at 312 Main Street.

The disciplinary function within the VPD was hampered because it acted upon and depended upon the flawed criminal investigation.

The evidence before me illuminated, through the life and death of this one Aboriginal man in Vancouver, the systemic challenges raised by the mentally ill and addicted who depend on the community for safety, medical care and the opportunity for rehabilitation. It is now clear that Frank Paul was burdened with a significant and debilitating mental disability.

Frank Paul was thought by many of the responders who testified to be a withdrawn and private person choosing a life on the streets. The evidence I have reviewed suggests instead that by reason of his mental disability and other medical conditions, he was a captive of his alcohol addiction and mental illness. Although the medical system treated his physical injuries and occasional illnesses well and at substantial public cost and effort, his mental disability was observed but not understood, diagnosed but untreated, and he lived under the shadow of a death brought about by accidental injury or another of the many risks of being mentally ill and without a home.

It has been said that Vancouver does not have a homeless problem as much as an untreated mental illness problem. The final chapter of Frank Paul's life is a testament to our need as a community to more effectively shelter and treat those who have suffered brain injury or are otherwise disabled by reason of mental illness.

Similarly, his alcoholism was a central feature of his identity to the professionals he encountered. Yet they were without the services to care for him effectively unless and until he first became sober.

It also matters that Frank Paul was a Mi'kmaq man. The circumstances of his life and death are an account in miniature of the risks and struggles faced by many First Nations people of his generation. It is not surprising to learn that Frank Paul was burdened with having been sent to residential school, losing members of his family to alcohol abuse and struggling from his early childhood to make sense of a world in which his family was fragmented and fractured. It is not surprising that he came to Vancouver and isolated himself from his family and community for the last two decades of his life. We cannot know when the psychic injuries of childhood were compounded by the addiction and mental illness of his adult years. We must acknowledge, however, that the tragic arc of his life was that followed all too frequently by members of the First Nations in our

community and that his death speaks out yet again of our need to revisit and refashion the important relationship between the First Nations peoples of Canada and the general community.

Although I comment on these lapses in some detail in the body of this report, I emphasize that the flaws which appear in the record raise important systemic questions, which in my view must be addressed by those responsible for the discharge of important public duties.

Mistakes marked by indifference, callousness, and failure to care, evident in the Frank Paul case, often occur within a system that neither requires nor facilitates best performances, nor holds individuals accountable for the effective discharge of their public duties.

The VPD investigation into the circumstances of Frank Paul's death was methodically flawed. In particular the unwritten, unpublished, and generally unknown policy of preparing so-called "neutral" reports into police-related shootings provided an unaccountable environment for the conduct of superficial investigations and inadequate Reports to Crown Counsel, and hence had the effect of ensuring that, despite police involvement in the death and assignment of responsibility to the Homicide Squad, facts were overlooked, suspicions unaddressed, and clarifying evidence left untouched.

The various explanations offered by Sgt. Russell Sanderson,[8] responsible for the Jail on the evening of December 5, 1998, must be rejected in their entirety. From any perspective Frank Paul was in need of care that evening, and if the superficial care of a sobering cell (commonly referred to as the "drunk tank") was to be kept from him, this experienced officer could not properly conclude that he could be safely discharged to the winter streets of Vancouver. I emphasize that the decision to reject Frank Paul from admission to the Jail, despite being sent there by two experienced and capable patrolmen to sober up, was a decision made in a moment and without any responsible level of attention or care.

Cst. David Instant, as the junior constable assigned to the drunk wagon while serving his probationary term, was in a confusing circumstance created by the dictates of

[8] Mr. Sanderson retired from the VPD prior to testifying, yet I have chosen to use his title at the time of this incident. The same approach has been used for all police witnesses, using their 1998/99 titles rather than their current titles.

paramilitary discipline and personal inexperience. I fully accept the profound sense of guilt and grief expressed by him during the inquiry. He was not an uncaring person, but was persuaded by his training and superiors to behave as if his natural sympathies and sense of humanity were out of place and inappropriate.

The decisions made that evening may also have been influenced by the late hour and the collective fatigue associated with doing an unpleasant job that may seem without great moment or value, in a setting where the decision makers sit at the bottom of the paramilitary hierarchy.

These judgments and actions also took place in an institutional setting where police officers are expected to act like paramedics and social workers with respect to the population of chronically homeless, mentally ill and addicted people in downtown Vancouver. Despite the VPD's efforts to get out of the business of jailing chronic alcoholics, the fact is that the Jail served as an emergency shelter for violent or unpleasant drunks who were socially irritating and for whom the options were involuntary detention at the Jail or voluntary detention at the sobering unit of the Detox Centre. No one believed these individuals had committed crimes deserving jail; rather, they were being jailed for their own safety.

The sobering unit at the Detox Centre had neither the resources nor the ability to cope with troubled or unruly individuals. Furthermore, it could not transition the homeless chronic alcoholic population into shelter unless and until they became and remained sober. For the many homeless chronic alcoholics whose primary disability was a mental illness, there was little or no psychiatric care accessible to them. Frank Paul himself was hospitalized on numerous occasions and identified as suffering from Wernicke-Korsakoff Syndrome and two or more closed head injuries. Nothing else appears to have been done to arrest the progress of his illness; his eventual deterioration, accompanied by the risks of accident, misadventure, related illness, and exposure to the elements, seemed more and more likely.

B. Executive Summary

1. The Commission of Inquiry

I was appointed as sole Commissioner in March 2007. The Terms of Reference (see Appendix A) instructed me to inquire into:

- The circumstances surrounding Mr. Paul's death.
- The response of five public bodies to his death.
- The rules, policies and procedures of those bodies in their interaction with people incapacitated by alcohol or drug use, or when an individual dies in similar circumstances.
- The health care and social services programs and facilities available in Vancouver for such people.

The Commission held 60 days of evidentiary hearings into the events leading up to Mr. Paul's death and the response of the five named public bodies to his death, at which 68 people testified. It also convened nine days of informal roundtable discussions of policy issues, and considered submissions from participants and members of the public.

The Criminal Justice Branch of the Ministry of Attorney General challenged the commission's jurisdiction to inquire into its response to Mr. Paul's death. That is, its decision not to approve criminal charges against any police officer. I ruled that I had jurisdiction to inquire into the matters otherwise considered an aspect of Crown privilege.[9] An application for judicial review of my ruling was dismissed by the British Columbia Supreme Court on July 24, 2008, and the matter is currently before the BC Court of Appeal. This Interim Report reports on all aspects of the inquiry's mandate except as it relates to the response of the Criminal Justice Branch. Depending on the outcome of this litigation, I may hear evidence and then publish a Final Report into the branch's response.

2. Frank Paul's last days

At 11:00 a.m. on December 5, 1998, two Vancouver police officers arrested Frank Paul for being in a state of intoxication in a public place. The police wagon transported him to the Jail. After Corrections officers removed his wet outer clothes and shoes, they placed him in a cell set aside for intoxicated people. At about 5:00 p.m., the sergeant in charge of the Jail released him, being satisfied that he could fend for himself. He was last seen leaving the loading bay area at about 6:30 p.m.

[9] See Appendix I.

At about 8:00 p.m. the same evening, two other officers found Frank Paul lying on a street-side vegetable stand, asleep. One officer smelled rice wine on Mr. Paul's breath and observed other signs of impairment, and formed the opinion that he was intoxicated. He directed the police wagon driver to transport Mr. Paul to the Jail (rather than to the civilian-run sobering unit attached to the Detox Centre), because Mr. Paul had a history of violence.

On arrival at the back of the Jail, Mr. Paul was incapable of walking, so the officer dragged Mr. Paul by the shoulders through the loading bay into the elevator (where Mr. Paul lay on the floor), and took him by the elevator up to the Jail. When the elevator reached the Jail floor and the door opened, the police van driver told the sergeant in charge of the Jail (a different sergeant than the one who had released Mr. Paul earlier that afternoon) that he had Frank Paul for being intoxicated. The sergeant responded that there was no way he could be drunk, having just left the Jail at 6:30 p.m. The sergeant disagreed with the van driver's statement that Mr. Paul could not even walk, saying that he had a disability, making him slow-moving and making him appear drunk. During the four minutes that the elevator was at the Jail floor, Mr. Paul remained on the floor of the elevator. His clothes were wet, he was not asked how he was feeling, if he was cold or why he appeared unable to move, and the Jail nurse did not examine him. The sergeant instructed the police wagon driver to take Mr. Paul to Broadway and Maple, which was the area where the sergeant understood that Mr. Paul had said he lived. The wagon driver and a Corrections officer took Mr. Paul back down in the elevator, dragged him through the loading bay and pulled him into the wagon.

According to the sergeant, officers arrested Mr. Paul every two or three days for being intoxicated in a public place, his appearance had not changed markedly from when he was released earlier that afternoon, and he concluded that Mr. Paul could not have gotten intoxicated between the time he left the Jail and was re-arrested.

After leaving the Jail and before dropping Frank Paul off, the wagon driver realized that he needed more information. When he stopped at the Cobalt Hotel to pick up three men in handcuffs, he told a more senior constable that the Jail sergeant had told him to drop Frank Paul off in the Broadway and Maple area.

The more senior constable told him that Frank Paul did not live there, and the best spot to drop him off would probably be in the lane leading to the Vancouver Detox Centre. The wagon driver said he would think about it.

The wagon driver then drove to the Detox Centre. He told staff there he was dropping off another of his passengers, but that Mr. Paul was not for Detox—he did not ask to have Mr. Paul admitted to Detox because he did not believe that he was drunk. He told two staff members that he was going to release Mr. Paul out of the area—a police department practice known as "breaching." After leaving the Detox Centre at just before 9:00 p.m., the wagon driver drove to the other end of the lane, looking for a location that he thought would be safe. He stopped, lifted Mr. Paul out of the side of the wagon, walked him over to the wall of a building and sat him down. He walked back to the wagon and got Mr. Paul's second shoe, and put it on him. According to the officer, the temperature was about five degrees Celsius, and it was rainy. He did not conduct his own assessment of Mr. Paul's state of intoxication or health, did not ask him how he was feeling, and agreed that the building afforded no protection from rain.

At about 10:00 p.m., a passenger in a taxi saw Mr. Paul prone in the middle of the alleyway, rising up on one or two elbows. At about 2:00 a.m. the next morning (December 6), a man looking for a lost cat found Mr. Paul's dead body in the alleyway, and called 911.

Following an autopsy, the pathologist attributed death to hypothermia due to, or as a consequence of, acute alcohol intoxication.

3. The institutional response to Frank Paul's death

The criminal investigation

Because this was a police-related death, it was immediately assigned to a detective in the Homicide Squad within the Major Crimes Section. At 4:40 a.m., members of the department's Forensic Identification Section attended the scene and took photographs of Mr. Paul's body and the general area where the body was found, but did not take other investigative steps normally a part of a homicide investigation, such as preparing a detailed sketch plan, noting the physical location of relevant items of evidence, taking measurements,

determining whether the body had been moved, and searching for fingerprints, tire marks, and hair and fibre.

The detective interviewed several civilian witnesses, obtained printouts of police calls and the 911 call from the civilian who had found the body, and gathered police records on Mr. Paul. However, he did not meet with or interview the many police officers, Corrections employees and Jail staff who had relevant evidence. Instead he asked these witnesses for written statements. As was the practice in police-related deaths, he did not ask the police wagon driver for a written duty report until after the officer had received legal advice.

In May 1999 the detective completed his Report to Crown Counsel, which included the various witness statements and a summary of the evidence gathered, but which did not offer any analysis of inconsistencies or characterize a witness's reliability or accuracy. It did not identify possible *Criminal Code* offences or whether the evidence matched the elements of those offences. It did not include any recommendations as to whether criminal charges should be laid and, if so, which charges and against whom. The detective sent his report to his superiors for their review, and to the chief constable's office, the coroners' office and the City Hall legal department.

In December 1999, Crown Counsel advised the VPD that criminal charges would not be laid.

I have concluded that the department failed to carry out an adequate investigation into the circumstances of Frank Paul's death and, in particular, that:

- the forensic identification officer attending was not provided with adequate instructions and did not carry out investigative steps which are standard to a potentially culpable homicide;
- the investigating officer did not locate, or interview several relevant witnesses;
- the investigating officer did not seek to interview police officers, Corrections employees, and Jail staff in circumstances where interviews were required; and

- the investigating officer did not identify or reconcile inconsistencies in the evidence or attempt to do so.

The professional standards investigation

In May 1999, a sergeant in the VPD's Internal Investigation Section (IIS) began a professional standards investigation to determine whether any police officer had breached the *Code of Professional Conduct Regulation*; a breach could lead to the chief constable imposing disciplinary measures, a responsibility imposed on him by the *Police Act*. The sergeant completed a Form 1 complaint form, characterizing it as a public trust complaint, and sent it to the Police Complaint Commissioner (PCC). Responsibility for this investigation was then transferred to another sergeant.

The new sergeant relied almost entirely on the Report to Crown Counsel. He did not request further reports from, nor interview, the Jail sergeant or the police wagon driver. He reviewed the two officers' human resources or personnel files. He initially considered an informal "management advice" disposition, but eventually decided that it would be inappropriate. He ultimately recommended that the Jail sergeant receive a two-day suspension without pay, for failing to have Mr. Paul medically assessed and failing to consider some other form of shelter, such as Saferide or the Detox Centre. He recommended that the police wagon driver receive a one-day suspension without pay, for changing the location of Mr. Paul's "breach" without consultation, and for failing to consider medical attention and proper shelter for him. He concluded that neither officer exhibited malice or culpable intent.

The chief constable agreed with the sergeant's report and accepted his recommendations, and the two officers accepted the proposed disciplinary measures.

I have concluded in relation to the professional standards investigation carried out by the VPD that:

- the investigating officer acted properly in initiating the complaint;
- the professional standards investigation was hampered by the inadequate criminal investigation;

- it was apparent that, as a result of departmental policy, full and complete interviews of the two subject officers were not conducted—neither for the criminal investigation nor for the professional standards investigation; and

- the determination of discipline was hampered by the absence of any concrete guidance as to the aggravating and mitigating circumstances to be considered in determining disciplinary or corrective measures, as well as by the limited scope of discretion permitted by way of suspension. The disciplinary punishment system unduly limited the penalties and also excluded from consideration the important dimension of remedial training of the officers involved.

The BC Coroners Service's response to Frank Paul's death

When a death is reported, the coroner is required to conduct an investigation and decide whether to proceed by way of a Judgment of Inquiry (written report) or an inquest (a public hearing before a jury). The objectives are to determine:

- who the deceased was,

- when, how and where the deceased died, and

- what recommendations may help prevent similar deaths in the future.

A coroner attended the scene at about 6:30 a.m., and took photographs, made observations of Mr. Paul's body and clothing, and directed that the body be removed for autopsy.

The pathologist concluded that arthritis had distorted Mr. Paul's ankles and hands, which would have affected his locomotion and dexterity. Two areas of brain injury may have been related to seizures. His blood-alcohol level (.29 grams percent) was nearly four times the legal limit, and would have been significantly higher some hours prior to his death.

A more senior coroner concluded that an inquest was discretionary, not mandatory, because Mr. Paul had not died while detained by, or in the actual custody of, police. After discussing the circumstances with the chief coroner, she understood that his statements were a directive not to hold an inquest. She reviewed the VPD's criminal investigation report, the autopsy report, and the Jail video (showing Mr. Paul being dragged in and out of the elevator). In her

Judgment of Inquiry she categorized the death as an "accident" rather than "homicide," and made several recommendations directed to the VPD.

The current chief coroner (not the chief coroner in 1999) acknowledged that it was the responsibility of the Coroners Service to notify and consult with the next of kin, and apologized to the Paul family for not having done so in this case. According to Mr. Paul's sister who lived in Maine, U.S.A., an RCMP officer phoned her and advised her of Frank's death, and that he had been killed as a result of a hit-and-run accident. She did not learn the real circumstances of his death until three years later.

The current chief coroner received requests from the PCC in 2000 and 2001, and from a different PCC in 2004, to re-open the Frank Paul case and order an inquest. He concluded that, while it would have been appropriate for an inquest in the first instance, he did not have the jurisdiction to re-open the matter and convene an inquest.

I have reached several conclusions respecting the Coroners Service's response of the death of Frank Paul, including:

- As acknowledged by the chief coroner, the Coroners Service failed in its duty to the Paul family to notify them of his death in a timely and accurate manner.

- The Coroners Service failed to maintain an adequate documentary record, to the extent that important conversations went undocumented and no contemporary evidence remains as to their contents. The inadequate process and communication associated with Mr. Paul's death at the coroner's office contributed to the Paul family's misunderstanding of how he died, and made it impossible later to conclude where and in what fashion a mischaracterization of his death arose.

- Inadequate attention was paid to the question of whether Frank Paul remained within the custody of the police in circumstances where he was removed by them from their physical custody, but in a condition where he could not care for himself.

- As acknowledged by the chief coroner in office at the time as well as the chief coroner now serving, it is clear that an inquest ought to have been held in the public interest based on the circumstances known at the time.

- It was reasonable for the Coroners Service to classify the death as accidental rather than homicide.
- The results of the Judgment of Inquiry and its four recommendations were appropriate and were arrived at professionally.

The BC Police Complaint Commissioner's response to Frank Paul's death

The PCC acts as a civilian overseer of a municipal police department's investigation of professional standards complaints.[10] When the PCC receives a department's report, he or she may:

- take no further action,
- order further reasons for disciplinary measures imposed,
- order an external investigation by another municipal police department, or
- order a public hearing.

When the PCC received the report of the Frank Paul professional standards investigation in June 2000, he concluded that more information was needed, and assigned it to a staff investigator. The investigator completed his file review in August 2000, recommending a public hearing in order to ascertain the truth of what happened. At a subsequent staff meeting it was agreed that a forensic pathologist should be retained for an expert opinion.

At a November 2000 staff meeting, the forensic pathologist presented his report, which included his opinion that Frank Paul might have been hypothermic while at the Jail. The PCC sent this report to the coroner, asking that she reconsider calling an inquest. Acting on the advice of his commission counsel, the PCC referred the matter back to Crown Counsel to reconsider whether criminal charges should be approved, and deferred a decision about ordering a public hearing under the *Police Act* until after the Crown's decision.

[10] PCC herein refers to the individual serving as commissioner, and the OPCC refers to the Office of the Police Complaint Commissioner as a whole.

In April 2001, the Deputy PCC recommended a public hearing but, after Crown Counsel advised the PCC in August 2001 that there would be no criminal charges, the PCC decided not to order a public hearing. His decision was based on the significant delay, the Crown's refusal—twice—to approve criminal charges—and the fact that the two officers had accepted their disciplinary sanctions. He considered the penalties inadequate. He also felt that a public hearing would at most increase the suspensions to five days: the maximum suspension permitted under the regulation.

Ten days later, during a restaurant lunch, the PCC advised the chief constable of his decision not to order a public hearing—a decision he did not make public until four months later. In the interim he attempted (unsuccessfully) to have an inquest ordered, and urged the Ministry of Public Safety and Solicitor General to undertake a province-wide review, including an examination of the police practice of "breaching" a person.

My conclusions with respect to the PCC include:

- The Office of the Police Complaint Commissioner (OPCC) identified the inadequacies in the criminal investigation and properly referred the matter back to Crown Counsel for reconsideration. Unfortunately, the consequence of calling upon other government agencies to reconsider the Paul matter meant that considerable additional delay was introduced to an already much-delayed process. It was reasonable for the PCC to conclude that it was not appropriate for him to conduct a public hearing.

- I have found it unnecessary to inquire into the causes and responsibility for the fractious atmosphere in the OPCC during the material period, but I have concluded that the office processes were inadequate, and documentation of the important decisions made by the OPCC were not properly kept and maintained.

Homeless chronic alcoholics

Although public intoxication is still an offence in British Columbia, in practice it has been decriminalized for the past four decades. The provincial *Offence Act* authorizes a police officer to take into custody a person who is in a state of intoxication in a public place and to hold the person without charge until they

have recovered sufficient capacity to be released without danger to themselves or others, or without causing a disturbance.

In Vancouver, persons intoxicated in public are transported to the sobering unit of the Detox Centre (operated by the Vancouver Coastal Health Authority) or, if they have a history of violence, to the Jail (which includes a separate holding facility for intoxicated people). Jail staff members are required to replace wet clothing and check on intoxicated prisoners every 15 minutes. Nursing staff must visually assess prisoners on admission, and every hour thereafter. Before release, Jail staff must ensure that prisoners are able to care for themselves, are dressed appropriately for the weather, and have a place to go and a means to get there. Chronic alcoholics are released with few or no community supports, and the cycle of release and re-arrest repeats itself with alarming regularity.

Homeless chronic alcoholics (of whom Frank Paul was representative) are a clearly identifiable sub-cohort of 50–200 individuals in Vancouver's Downtown Eastside, with predictable patterns of behaviour and unique needs.

A research study commissioned by the inquiry found that, although Aboriginals may constitute about 40 percent of Vancouver's chronic alcoholics, there are no Aboriginal organizations in the Downtown Eastside equipped to provide comprehensive services to chronic alcoholics in a similar position to Frank Paul.

In the late 1990s, the City of Vancouver (including the police department), the health board and the provincial Ministry for Children and Families developed a proposal for a civilian-run sobering centre (offering a 7–12 hour safe haven for those acutely intoxicated), and a 72-hour non-medical detoxification program. However, this initiative failed due to differing funding priorities and serious disagreements over responsibility for chronic alcoholics.

Several recent studies have documented the interrelationship between homelessness, mental illness and addiction, and the need for programs that provide permanent, independent low-barrier housing (without time limits or requirements for engagement in treatment); multidisciplinary Assertive Community Teams (providing intensive case management in the community); and a harm reduction approach (that may accept alcohol on-site or provide

measured amounts of alcohol to residents, to prevent bingeing). One study[11] found that in BC the average homeless adult living on the street with severe addictions and/or mental illness costs the public system more than $55,000 per year, while provision of adequate housing and supports would reduce this cost to approximately $37,000 per year.

Based on a review of the academic literature and innovative programs in several other jurisdictions, I recommended a civilian-based response to public intoxication, including a civilian-operated program for attending to chronic alcoholics who are incapacitated in a public place, replacement of the sobering cells in the Jail with a civilian-operated sobering centre, and an enhanced civilian-based detoxification program.

I also recommended the provision of permanent low-barrier housing designed for the specific needs of chronic alcoholics, which would offer (if needed) palatable alcohol substitution and managed alcohol programs, and the provision of community-based, multidisciplinary assertive community treatment services.

The criminal investigation of police-related deaths

"Police-related deaths" include deaths in a police jail cell, from an officer's use of force, or arising from, or soon after, some other form of police interaction with the deceased (as in the Frank Paul case). In such cases, the VPD assigns the criminal investigation to the Homicide Squad within the Major Crime Section.

There are two significant differences between how the department investigates police-related deaths specifically, and how it investigates deaths from possible homicide generally. First, in a police-related death, the investigating officers do not normally attempt to interview the subject officer. Instead, they rely on the officer's written duty report, which the officer has at least five business days to prepare, after a maximum of 10 hours of consultation with a lawyer (paid for by the department).

[11] Patterson, Michelle, et al. "Housing and Support for Adults with Severe Addictions and/or Mental Illness in British Columbia." (Vancouver: Centre for Applied Research in Mental Health and Addiction, Faculty of Health Sciences, Simon Fraser University, 2008), pp. 10–11, see http://www.carmha.ca/publications/index.cfm?contentID=29. Throughout this document we have provided website references, though it must be kept in mind that they may change over time or become unavailable. They are up to date as of Dec. 10, 2008. Wherever possible, we have provided references to the original documents.

Second, the investigating officers' Report to Crown Counsel is "neutral," in that it does not recommend whether criminal charges should be laid and, if so, what charges and against whom. In regular homicide investigations, the officers complete a Report to Crown Counsel only when criminal charges are recommended, and the report identifies the offences and the evidence supporting each charge.

I have concluded that the current practice of a home police department conducting criminal investigations of police-related deaths is fundamentally flawed, due to the conflict of interest inherent in police investigating their fellow officers. This conflict of interest finds expression in several aspects of the current practice—the municipality's civil legal liability for a police officer's misconduct, preferential treatment of the subject officer during the criminal investigation, the unwritten policy of providing "neutral" Reports to Crown Counsel and the Criminal Justice Branch's different charge assessment procedures in police-related deaths.

A new system for the criminal investigation of police-related deaths is required, which must take into account independence, competence, capacity to respond immediately, access to specialized services, the ability of smaller police departments to participate, cost and accountability.

I have considered several alternatives to a home police department conducting criminal investigations of police-related deaths: another municipal police department or the RCMP; a police-based investigatory team (dedicated or ad hoc); or a civilian-based investigatory team. I have concluded that the only alternative that satisfactorily addresses concerns about conflict of interest is the civilian-based investigatory team model. Ontario's experience with its Special Investigations Unit (SIU) shows that, with adequate resourcing, a civilian-based team can conduct competent criminal investigations at a reasonable cost.

I recommended that the provincial government establish an Independent Investigation Office (IIO), to conduct criminal investigations of all police-related deaths in the 12 jurisdictions policed by the 11 municipal police departments. The Office's investigators would attend the scene and assume full investigative responsibility. The IIO would recommend whether criminal charges should be laid (and, if so, what charges and against whom).

The professional standards investigations of police-related deaths

After the criminal investigation of a police-related death is completed, the VPD assigns an officer in its Professional Standards Section to conduct a professional standards investigation, to determine whether any officer has breached the *Code of Professional Conduct Regulation*; such a breach may lead to the chief constable imposing disciplinary measures. This process is subject to a primarily after-the-fact civilian oversight by the PCC.

Several studies have recommended variations to this "police investigating themselves" approach:

- In 1994 Justice Oppal recommended that the civilian overseer have the authority to conduct an investigation when the PCC thought it appropriate.
- In 2002 the Special Committee of the Legislative Assembly favoured retention of the current model of a home police department conducting professional standards investigations, but recommended that the PCC's powers include a power to inquire into the conduct of a police officer.
- In 2006 the PCC recommended that professional standards investigations of death and serious injury cases should be removed from the home police department, and assigned to a specialized unit of police officers drawn from municipal police departments and the RCMP; if government considered this alternative impractical, then such investigations should be assigned to the PCC.
- In 2007 former Justice Josiah Wood recommended that professional standards investigations of in-custody and police-related deaths should always be conducted externally, but not limited to other municipal police departments or the RCMP.

The practice across Canada varies. In Manitoba, the civilian Law Enforcement Review Agency investigates *all* professional standards complaints. In Saskatchewan, the civilian Public Complaints Commission decides whether a police-related death or serious injury will be investigated by the commission itself, by the home police department, or by another police department; and the Deputy Minister of Justice must appoint an investigation observer. In Ontario, a new Independent Police Review Director will decide who will conduct any

professional standards investigation—the home police service, another police service or the new body itself.

I have concluded that the same conflict of interest that undermines a home police department's criminal investigation of a police-related death taints its professional standards investigations as well. I have considered other police-based investigation models, but conclude that they are still instances of the police investigating themselves and would not receive general public acceptance.

I recommended that BC adopt a civilian-based model, in which the PCC would conduct professional standards investigations of police-related deaths.

I also endorsed the PCC's recommendation that respondent police officers have a professional obligation to cooperate in professional standards investigations, including a duty to provide reports.

C. Summary of Recommendations

HOMELESS CHRONIC ALCOHOLICS

1. I recommend that the City of Vancouver, the Vancouver Coastal Health Authority, the provincial Ministry of Housing and Social Development, and the Aboriginal community jointly develop a comprehensive response to the needs of homeless chronic

alcoholics within the city of Vancouver. This would include (but not be limited to) the following components:

- **a civilian-operated program for attending to chronic alcoholics who are incapacitated in a public place,**
- **a civilian-operated sobering centre,**
- **an enhanced civilian-based detoxification program,**
- **the provision of permanent low-barrier housing designed for the specific needs of chronic alcoholics, which would offer (if needed) palatable alcohol substitution and managed alcohol programs, and**
- **the provision of community-based, multidisciplinary assertive community treatment services.**

2. **I recommend that the Lieutenant Governor in Council appoint a highly respected third party, knowledgeable about the issues but independent of any of the interests involved, to assume an overall leadership role in the development of the response.**

3. **I recommend that the provincial Ombudsman—if the Ombudsman is agreeable—monitor progress of the comprehensive response for a three-year period and on an annual basis make a special report to the Legislature and comment publicly on progress made on this initiative.**

THE CRIMINAL INVESTIGATION OF POLICE-RELATED DEATHS

4. **I recommend that British Columbia develop a civilian-based criminal investigation model for the investigation of police-related deaths occurring in the municipalities policed by the 11 municipal police departments.**

5. **I recommend that the initial mandate of this organization (which I suggest be named the Independent Investigation Office (IIO)) include a wide variety of factual circumstances, including (but not limited to) a death in a police department jail**

cell, a death resulting from an officer's use of force or a motor vehicle, or a death arising from some other form of police interaction with the deceased.

6. **I recommend that the IIO be accountable to the Ministry of Attorney General.**

7. **I recommend that the IIO be led by a director appointed by Order in Council for a fixed term of five or six years.**

8. **To ensure the IIO's unquestioned authority to act, I recommend that its essential powers be entrenched in legislation, such as:**

- **the IIO director and investigators have the status of peace officers,**
- **the chief constable of the jurisdiction in which a police-related death occurs must immediately advise the IIO of the incident,**
- **pending arrival of the IIO at the incident scene, the chief constable must ensure that the scene is secured and that officers involved in the incident are segregated from each other,**
- **officers involved in the incident must not communicate with each other about the incident, except as authorized by the IIO,**
- **the IIO becomes the lead investigative agency, and the home police department has no investigative responsibility or authority, except as granted by IIO,**
- **a witness officer must promptly make himself or herself available for an interview with the IIO investigator, and must promptly deliver to the IIO all notes, reports and other investigative materials relevant to the incident, and**
- **a respondent officer may be—but is not compelled to be—interviewed by the IIO, and must in all cases promptly deliver to the IIO all notes, reports and other investigative materials relevant to the incident.**

9. I recommend that the director recommends to the Criminal Justice Branch whether criminal charges should be laid, and if so, which charges, involving which officer or officers.

10. I recommend that the provincial Ombudsman have jurisdiction over the IIO.

THE PROFESSIONAL STANDARDS INVESTIGATIONS OF POLICE-RELATED DEATHS

11. I recommend that the statutory mandate of the Police Complaint Commissioner be extended to include the requirement that the commissioner conduct professional standards investigations of all police-related deaths arising in those British Columbia jurisdictions policed by municipal police departments.

12. I recommend that Recommendations 29–34 of Mr. Wood's 2007 Report be implemented.

PART 2—THE COMMISSION OF INQUIRY

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A. The Commission

1. Appointment of Commissioner

On February 22, 2007, then-Solicitor General John Les announced that, in view of the public concern and need to ensure public confidence in the administration of justice, there would be a public inquiry into the December 1998 death of Frank Paul.

On March 9, 2007, Mr. Les announced my appointment as Commissioner. He stated that it was the Province's intention that this inquiry be conducted under the new *Public Inquiry Act*, which had been introduced in the Legislative Assembly four days earlier. The Act came into force on June 21, 2007.

2. Terms of Reference

Section 2 of the *Public Inquiry Act* states that the Lieutenant Governor in Council may establish a commission to inquire into and report on a matter that it considers to be of public interest. When it does, the Lieutenant Governor in Council must define the purposes of the commission, set the terms of reference of the inquiry and designate the commission as a study commission, hearing commission or both.

The Lieutenant Governor in Council designated this inquiry as a hearing and study commission and, on August 10, 2007, published the Purpose and Terms of Reference,[12] which state as follows:

Purpose:

(a) to provide Mr. Paul's family and the public with a complete record of the circumstances relating to Mr. Paul's death;

(b) to recommend changes considered necessary to the rules, policies and procedures referred to in section 4(c), (d) and (e).

Terms of reference:

(a) to conduct hearings, in or near the City of Vancouver, into the circumstances surrounding the death of Mr. Paul;

[12] See Appendix A.

(b) to make findings of fact regarding circumstances relating to Mr. Paul's death, including findings of fact respecting the response of the British Columbia Ambulance Service, the VPD, the BC Coroners Service, the Office of the Police Complaint Commissioner and the Criminal Justice Branch of the Ministry of Attorney General to the death of Mr. Paul;

(c) to examine the rules, policies and procedures of the Vancouver Police Board and of the VPD respecting police interaction with persons who are incapacitated by alcohol or drug use, including directions for the handling, detention, transportation and release of individuals who, as a result of alcohol or drug use, are incapacitated, violent, unable to care for themselves, self-destructive or unconscious;

(d) to examine the rules, policies and procedures of the British Columbia Ambulance Service respecting the interaction of staff of the British Columbia Ambulance Service with persons who are incapacitated by alcohol or drug use, including directions for the handling and transportation of individuals who, as a result of alcohol or drug use, are incapacitated, violent, unable to care for themselves, self-destructive or unconscious;

(e) to examine the rules, policies and procedures of the BC Coroners Service, the office of the Police Complaint Commissioner and the Criminal Justice Branch of the Ministry of Attorney General related to the role and response of each of those offices where an individual dies in circumstances similar to the circumstances of Mr. Paul's death;

(f) to recommend changes considered necessary to the rules, policies and procedures referred to in paragraphs (c), (d) and (e);

(g) to identify the health care and social service programs and facilities available in the City of Vancouver that the police may access if a municipal constable determines that a person should not be detained but the person requires immediate health care or social services because the person is incapacitated by alcohol or drug use;

(h) to submit a final report to the Attorney General on or before June 30, 2009.[13]

[13] The original Terms of Reference required that I submit my final report to the Attorney General on or before May 31, 2008. By early 2008 it became clear that this report date was no longer realistic, given the number of participants involved (14), the number of witnesses called during the evidentiary hearings (68), the deadline for receiving oral closing submissions (May 16) and written closing submissions (May 30), the need to undertake research on several important policy issues and the time required to formulate my recommendations, and draft the inquiry report. Consequently, on March 20, 2008, I wrote to the Deputy Attorney General, requesting an extension of time until December 31, 2008, to file my report. On May 15,

3. The Commission team

In the weeks following my appointment, I appointed Louise Stuart to act as General Manager. Ms. Stuart, a retired court clerk, had served in a similar capacity in several previous inquiries and, overcoming daunting challenges, secured office space for the inquiry in downtown Vancouver and promptly took charge of innumerable administrative tasks.

I retained as Commission Counsel D. Geoffrey Cowper, Q.C., a partner in the Vancouver office of Fasken Martineau DuMoulin LLP. Mr. Cowper is a senior civil litigator, and he brought valuable experience as counsel to several other public inquiries. I retained Brock Martland as Associate Commission Counsel. Mr. Martland is a criminal law practitioner in Vancouver, with valuable related experience in several *Police Act* cases. In light of the significant policy issues arising from the Terms of Reference, I retained Keith R. Hamilton as Policy Counsel. Mr. Hamilton has participated as policy counsel and principal report writer in a number of earlier public inquiries.

As the inquiry's administrative workload increased dramatically prior to and during the evidentiary hearings, Sharon Dunn and Nadine Rosario joined our administrative staff. In addition, Mr. Cowper's firm agreed to second Keri Gammon, an articling law student, to assist Messrs. Cowper and Martland during the evidentiary hearings. She very quickly became a valuable member of our team. I was fortunate to be able to obtain Len Giles to act as Registrar. His experience in the Tax Court of Canada was invaluable in administering the hearings that involved, at times, 22 lawyers.

I also retained Ardith Walkem, a Vancouver lawyer and member of the Nlaka'pamux Nation, to identify the health care and social services programs and facilities that are currently available in the city of Vancouver, that have been developed specifically for Aboriginal men and women who are incapacitated by alcohol or drug use. In addition, I asked her to consult with the Aboriginal community in the Downtown Eastside, to determine what additional health care and social services programs and facilities they think are necessary, in order to

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2008, the Lieutenant Governor in Council granted an extension to November 30, 2008. Owing to the pending appeal before the Court of Appeal, and drafting considerations with the interim report, a request for a further extension was submitted August 21, 2008. My office received notice November 28, 2008, that an extension to June 30, 2009, had been granted by the Lieutenant Governor in Council.

address the needs of Aboriginal men and women who are incapacitated by alcohol or drug use. Her report, which I will discuss later, is included as Appendix L.

I cannot say enough about the professionalism, commitment and hard work that everyone brought to this task. It turned out to be a more complex and protracted inquiry into the events leading up to and following Mr. Paul's death than we initially contemplated, and we were confronted with several important yet intractable policy issues. While I accept sole responsibility for my findings of fact and recommendations, in all other respects it has been a team effort, and I am gratified at my good fortune in the team that came together.

4. The Commission's activities

As the Terms of Reference reveal, this inquiry's mandate included, but went far beyond, a forensic examination of the death of Mr. Paul. For that reason, I divided the inquiry's activities into four phases:

Phase 1 would be a detailed examination of the events of December 5 and 6, 1998, leading up to the death of Mr. Paul.

Phase 2 would examine the response of five public agencies to Mr. Paul's death—the VPD, the BC Ambulance Service, the BC Coroners Service, the Police Complaint Commissioner and the Criminal Justice Branch of the Ministry of Attorney General.

Phase 3 would identify the current health care and social service programs and facilities available in the city of Vancouver that a police officer may access, when the officer determines that a person should not be detained but requires immediate health care or social services due to incapacitation by alcohol or drug use.

Phase 4 would be a detailed examination of the current rules, policies and procedures of the five public bodies noted above, respecting:

- their interaction with people incapacitated by alcohol or drug use, or
- their response when an individual dies in circumstances similar to the circumstances of Mr. Paul's death.

Phases 1 and 2 constituted the fact-finding aspects of the inquiry. I held evidentiary hearings, at which witnesses testified under oath or affirmation, and were subject to cross-examination.

Phases 3 and 4 addressed the policy issues arising from the Terms of Reference. I invited written submissions on the health care and social services addressed in paragraph (g) of the Terms of Reference. In order to get a better understanding of the current rules, policies and procedures of the five named public bodies, I convened nine days of informal roundtable discussions at which those bodies and other participants made presentations and, in some cases, brought in experts from other Canadian and U.S. jurisdictions.

At the same time Keith Hamilton, my Policy Counsel, conducted his own examination of these policy issues, and produced discussion papers for my consideration. Our team also held briefing sessions with experts in the field of providing health care and social services programs for people like Frank Paul, and Mr. Hamilton visited several facilities in Vancouver and Portland, Oregon.

In the preparation of this report, Messrs. Cowper and Martland assisted me in summarizing the evidence arising from the Phase 1 and 2 evidentiary hearings, and Mr. Hamilton assisted me with the policy issues arising out of Phases 3 and 4.

Near the conclusion of the evidentiary hearings, counsel for several participants expressed concern regarding Commission Counsel's involvement in the drafting of the Inquiry Report. For instance, one participant counsel was concerned that Commission Counsel had taken an adversarial position during the hearings in relation to some witnesses and parties and that, consequently, Commission Counsel should not participate in the writing of the report. Another counsel expressed concern regarding Commission Counsel making closing submissions and then preparing the report.

I gave careful thought to those concerns. I fully understand that, when professional reputations are at stake, the commissioner must be the one making findings of fact, and in doing so must rely exclusively on the evidentiary record.

I have reviewed the practice followed by other public inquiries, the views expressed in several treatises on the conduct of public inquiries and in journal articles written by former commissioners, and the relevant case law. Not surprisingly, practice and opinion vary.

From this review, I concluded that while others may act as impartial advisors to a commissioner in the drafting of the report, it is the commissioner alone who should make decisions about credibility, findings of fact and findings of misconduct. If, during final submissions, commission counsel does not go beyond presenting a balanced view of the evidence, commission counsel may act as an impartial advisor to the commissioner in the drafting of the report.

In this inquiry, the role of Commission Counsel and Associate Commission Counsel was to call and question the witnesses (except in those few instances where I permitted counsel for a witness to examine that witness), and to ask further questions following cross-examination by other counsel. An inquiry is not bound by the rules of evidence applicable to court trials, and it was appropriate for them to ask leading questions and, when necessary, press a witness on particular issues. The goal of the inquiry process is to ascertain the truth about what happened, and sometimes that requires challenging a witness's recollection or pressing for responsive answers. In my view, doing so does not place counsel in an adversarial position. I am satisfied that neither Commission Counsel nor Associate Commission Counsel took on an adversarial role.

Given the volume of evidence before the inquiry, I considered it essential that Messrs. Cowper and Martland assist me in summarizing the evidentiary record. For that reason, and in light of the concerns expressed by counsel, I instructed Commission Counsel not to make any closing submissions. My instructions to them were clear—while they could act as impartial advisors to me in the drafting of the report, I alone would make decisions about credibility, findings of fact and findings of misconduct. This report has been prepared on that basis.

5. The new *Public Inquiry Act*

This inquiry was the first conducted under the 2007 *Public Inquiry Act*, which can be viewed on the inquiry's website.[14]

B. Evidentiary Hearings

1. Rules of procedure

Section 9(1) of the Act authorizes a commission to control its own processes and to make directives respecting practice and procedure, in order to facilitate the just and timely fulfillment of its duties.

Accordingly, I approved a 31-paragraph Practice and Procedure Directive for Evidentiary Hearings,[15] based in part on precedents used by other public inquiries from across Canada.

2. Participants and counsel

Section 11 of the Act permits any person to apply to a commission to be a participant. A commission may accept an applicant as a participant after considering all of the following:

- whether, and to what extent, the person's interests may be affected by the findings of the commission,
- whether the person's participation would further the conduct of the inquiry, and
- whether the person's participation would contribute to the fairness of the inquiry.

I initially received 11 written applications for participant status. On October 17, 2007, I issued Ruling 1,[16] in which I granted participant status to the Paul family, to the five public bodies named in the Terms of Reference, and to four other organizations.

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[14] See http://www.frankpaulinquiry.ca/legislation.php.
[15] See Appendix B. The Directive can also be viewed on the inquiry's website: http://www.frankpaulinquiry.ca/rules-of-procedure.php.
[16] See Appendix F. The Ruling is also available on the inquiry's website: http://www.frankpaulinquiry.ca/applications-for-participant-status.php.

On November 26, 2007, I issued Ruling 2,[17] in which I granted participant status to one current and one former VPD officer, both of whom had played significant roles in the events of December 5 and 6, 1998.

On January 29, 2008, I issued Ruling 3,[18] in which I granted participant status to two former police complaint commissioners.

In total, I granted participant status to the following 14 individuals and organizations (listed alphabetically), all of whom were represented by counsel:

Participant	Counsel
Aboriginal Legal Services of Toronto	Kimberley Murray Jonathan Rudin
BC Ambulance Service and Emergency Health Services Commission	Douglas Eastwood
H. Benjamin Casson	Terrence Robertson, Q.C. Kathleen Kinch
BC Civil Liberties Association	Michael Tammen Grace Pastine Catherine Wong
BC Coroners Service	Rodrick MacKenzie Steven Boorne
Criminal Justice Branch, Ministry of Attorney General	Richard Peck, Q.C. Timothy Hinkson
First Nations Leadership Council	Steven Kelliher
David Instant	David Crossin, Q.C. Michael Shirreff
Don Morrison	Joseph Arvay, Q.C. Elin Sigurdson Bruce Elwood
Paul Family	Steven Kelliher
Police Complaint Commissioner (current)	Frank Falzon, Q.C.
Russell Sanderson	Kevin Woodall
United Native Nations Society	Cameron Ward David Eby Lobat Sadrehashemi
Vancouver Police Department and Vancouver Police Board	George Macintosh, Q.C. Sean Hern Anthony Price

[17] See Appendix G. The Ruling is also available on the inquiry's website: http://www.frankpaulinquiry.ca/applications-for-participant-status_ruling2.php.
[18] See Appendix H. The Ruling is also available on the inquiry's website: http://www.frankpaulinquiry.ca/participant_status_police_complaint.pdf.

I felt at the time these applications were made that it was important to hear from a wide range of interests and perspectives, given the controversy surrounding Mr. Paul's death and the important social policy issues under review. I express my thanks to all who participated in this inquiry.

I extend special appreciation to Messrs. Cowper and Martland for the timely organization of witnesses at the hearings, and to counsel for all participants, all of whom came into these proceedings with busy law practices, and yet made exceptional efforts to reschedule other commitments so that our evidentiary hearings could proceed expeditiously. I have never before witnessed so many lawyers in one room work with such professional collegiality, while at the same time forcefully representing their clients' interests.

3. Hearings

The evidentiary hearings commenced on November 13, 2007, with opening statements by counsel for most participants.

I also heard at that time from Peggy Clement, who is Frank Paul's cousin. I had asked that someone who knew Frank Paul in his earlier life come and speak, so that I could learn as much as possible about Mr. Paul. There is a risk that these types of proceedings become focused on a detailed forensic examination of who did what, when. While that was an important aspect of my work, I constantly reminded myself that we were all here because of one man whose life, however difficult, ended tragically. I felt it important to put Mr. Paul's final days into a broader context. I express my sincere gratitude to Ms. Clement for travelling from New Brunswick, and for telling us all so eloquently about the Frank Paul she knew.

It is significant that the first purpose of this inquiry, as stated in the August 10, 2007, Purpose and Terms of Reference, is to provide Mr. Paul's family with a complete record of the circumstances relating to his death. Although it has taken almost a decade to do so, I am confident that this goal has now been achieved. It is my hope that, with this report, Ms. Clement and other members of the Paul family can now find some peace and closure.

There were 60 days of evidentiary hearings between November 13, 2007, and April 25, 2008.[19] I heard testimony from 68 witnesses, including several by teleconference.[20] This evidence generated 8,373 pages of transcript.

Counsel for the participants made closing oral submissions over nine days, between May 9 and 16, 2008. I also invited written submissions from participants (by May 23, 2008), and written responses to other participants' written submissions (by May 30, 2008).

In the preparation of this report I have carefully taken into account the well-considered submissions of counsel for the participants, regarding both the facts and their recommendations. Those submissions were detailed, critical, and influential. They enabled me to appreciate many issues in the evidence and I do not hesitate to say that they improved this inquiry's work. This report, however, would become awkward to read if I were to recite each of the participants' submissions on each and every issue throughout the body of my report. Thus I have attached a detailed summary of those submissions as Appendix K—so that the public is aware in general terms of the positions taken before me.

Our evidentiary hearings were conducted in a large courtroom of the Federal Court of Canada, in a Vancouver office tower. It was conveniently situated in the downtown core, and was ideal for accommodating so many counsel, as well as family members, members of the public and representatives of the print and electronic media. I extend my sincere thanks to the Federal Court, and particularly to Mr. Sam Thuraisamy and his staff, for providing the courtroom and offices.[21]

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[19] See Appendix D for a list of witnesses who testified at the evidentiary hearings, and the dates of their testimony. This information, along with the transcripts of witnesses' evidence, is also available at http://www.frankpaulinquiry.ca/.

[20] On April 29, 2008, counsel for one participant applied for an order that three additional witnesses be called to testify. On May 13, 2008, after considering written submissions and hearing oral argument, I dismissed the application. My Ruling can be found at Appendix G.

[21] Our policy roundtable discussions were conducted at the BC Human Rights Tribunal's facilities in downtown Vancouver, and closing submissions were made in a courtroom of the BC Provincial Court at Robson Square, Vancouver. I also extend my sincere appreciation to those who made the BC Human Rights Tribunal's facilities in downtown Vancouver available for our roundtable discussions; and to those who made a courtroom of the BC Provincial Court at Robson Square available for our closing submissions.

4. Findings of misconduct

The Supreme Court of Canada has ruled[22] that a commission of inquiry may make findings of misconduct, which it interpreted as "improper or unprofessional behaviour," or "bad management." The Court recognized that a finding of misconduct may damage a person's reputation, but damaged reputations may be the price that must be paid, to prevent a recurrence of a disaster. Findings of misconduct should not be the principal focus of a public inquiry; they should be made only in those circumstances where they are required to carry out the mandate of the inquiry.

The Court added that a commissioner should endeavour to avoid making evaluations of his or her findings of fact in terms that are the same as those used by courts to express findings of civil or criminal liability. However, a commissioner should not be expected to perform linguistic contortions to avoid language that might conceivably be interpreted as importing a legal finding.

Section 21 of the *Public Inquiry Act* legislates a commission of inquiry's authority to make findings of misconduct. It states:

(1) Subject to this Act and the commission's terms of reference, a hearing commission may engage in any activity necessary to effectively and efficiently fulfill the duties of the commission, including doing any of the following:...

(d) making a finding of misconduct against a person, or making a report that alleges misconduct by a person.

Section 11 establishes procedural safeguards, before a finding of misconduct can be made:

(2) If a hearing commission intends to make a finding of misconduct against a person, or intends to make a report that alleges misconduct by a person, the hearing commission must first provide the person with

(a) reasonable notice of the allegations against that person, and

(b) notice of how that person may respond to the allegations.

[22] *Canada (Attorney General) v. Canada (Commission of Inquiry on the Blood System in Canada - Krever Commission)*, [1997] 3 S.C.R. 440 (S.C.C.).

At the conclusion of the evidentiary hearings, Commission Counsel delivered several Confidential Notices, which advised recipients that "the Commissioner may make the following findings that may amount to misconduct," and then itemized those possible findings. Counsel for the recipients of those notices addressed the allegations during their closing submissions.

5. Criminal Justice Branch's legal challenge

Paragraph (b) of the Terms of Reference instructed me "to make findings of fact ... respecting the response of ... the Criminal Justice Branch of the Ministry of Attorney General to the death of Mr. Paul."

According to a media release issued by the branch before this inquiry was established, five separate charge assessments were conducted to determine whether any criminal charges should be laid arising out of Mr. Paul's death. The Assistant Deputy Attorney General in charge of the branch reviewed all these charge assessments and, in all instances, charges were not laid.

Commission Counsel intended to call all those prosecutors who had conducted charge assessments (two of whom had since been appointed to the Bench), and the Assistant Deputy Attorney General. However, counsel for the branch brought an application challenging my jurisdiction to inquire into the branch's response to Mr. Paul's death. The branch's position was set out in para. 3 of its December 17, 2007, written submission, which states:

> It is submitted that the scope of the inquiry's jurisdiction to inquire into the Criminal Justice Branch is, at law, limited to inquiring into information from Criminal Justice Branch officials that relates to the Charge Approval policy. The Paul Inquiry cannot inquire into legal advice given or received by Crown Counsel in the employ of the Criminal Justice Branch or the exercise of discretion in an individual case. Accordingly, the Crown cannot be subpoenaed to testify either at trial or at an inquiry about why a charge was laid, or not laid, in any given case, nor can documents relating to this function be ordered disclosed. This immunity flows from the constitutional principle of Crown independence and from the privilege that attaches to legal professional advice.

According to the branch, no individual prosecutor involved in the Frank Paul case could be subjected to questioning about the facts he or she considered in reaching the decision that no charges were warranted, nor questioned on matters relating

to the exercise of discretion in the case. However, the branch offered to tender an appropriate senior branch official to provide a statement of the broad reasons for not prosecuting this matter, outlining the facts underlying the decisions, the process followed, and the standard applied.

I heard three days of oral argument on January 17 and 18, and February 20, 2008, which included submissions from three other participants. I delivered a Ruling on February 27, 2008,[23] in which I reached the following conclusions:

> 171. I am satisfied that the charge assessment process includes an element of prosecutorial discretion that must be exercised independently, in order to ensure that a charge/no charge decision is made in the public interest after a review of all relevant materials.
>
> 172. The courts recognize that some aspects of the charge assessment process should be protected from external interference. For the purposes of this motion, I adopt the branch's position that the core area of prosecutorial discretion that is protected from external interference relates to the charge/no charge decision and the basis for a proper charge.
>
> 173. The types of external interference that are precluded include such matters as disciplinary proceedings that may lead to sanctions being imposed against the prosecutor, or judicial proceedings that may result in the prosecutor's decision being criticized, quashed or reversed or that may expose the prosecutor to civil liability.
>
> 174. However, a commission of inquiry's examination of how the charge assessment process was conducted in a particular case is qualitatively different from these types of external interference, because it is limited to ascertaining what happened and, where appropriate, making recommendations for reform. It is not binding on, nor can it impose sanctions against, a prosecutor arising out of the exercise or prosecutorial discretion.
>
> 175. Consequently, I am satisfied that the principle precluding external interference with the exercise of prosecutorial discretion does not apply to a commission of inquiry, and that this inquiry is authorized to inquire into the charge assessment processes followed in the Frank Paul case, including an examination of all relevant information and documents, and the questioning of the individuals

[23] See Appendix I. The Ruling is also available on the inquiry's website: http://www.frankpaulinquiry.ca/commissioners_ruling_4.pdf.

who made charge assessments. That questioning may include an examination of their charge/no charge decisions (respecting which I understand there is no dispute), and the reasons for them.

176. While I consider it essential that the reasons for these decisions become part of the public record so that the public has a complete understanding of them, I do not propose to express any opinion about those decisions.

177. Had I concluded that this core area of prosecutorial discretion is immune from review by a commission of inquiry generally, then I am satisfied that such immunity from review does not apply to a commission appointed under the BC *Public Inquiry Act*, because s. 29 of that Act has clearly and unequivocally defeated any common law immunity. That being so, the "immunities" referred to in s. 13(2)(a) must be presumed to refer only to other immunities.

178. Further, had I concluded that this core area of prosecutorial discretion is immune from review by a commission of inquiry appointed under the BC *Public Inquiry Act*, then several results would follow. I would be precluded from inquiring into the charge/no charge decision and the basis for a proper charge. However, I would still be entitled to inquire into all aspects of the charge assessments prior to that final stage, and to require that the prosecutors who made charge assessment decisions testify respecting those matters.

179. I am satisfied that the relationship between the salaried prosecutors in the branch, and the Assistant Deputy Attorney General, does not constitute a solicitor-client relationship, and that consequently no solicitor-client privilege attaches to communications between them.

180. However, if I had concluded that a solicitor-client relationship did exist, I am satisfied that privilege has been waived in this case, either because of s. 29 of the *Public Inquiry Act*, or because of the Terms of Reference that instruct me to inquire into the branch's response to Mr. Paul's death.

181. Even if I had concluded that there was no waiver in this case, I am satisfied that the individuals who made charge assessment decisions in the Frank Paul matter can be required to testify as to what they did, what materials they reviewed, what decision they made and the reasons for it, and any other matters that do not constitute communications between themselves and the Assistant Deputy Attorney General respecting his exercise of prosecutorial discretion.

> 182. In closing, I wish to repeat what I said earlier. The fact that the branch was included among the public bodies enumerated in Term of Reference (b) satisfies me that there is public concern respecting the branch's response, and this concern relates to both the processes followed and the decisions made. That being so, the branch is currently under a cloud, for its response to Mr. Paul's death. It is too early to tell whether or not that cloud is warranted. Only a full and public examination of the branch's charge assessment will resolve that issue. While I am satisfied that Term of Reference (b) instructs me to inquire into the charging decisions made and the reasons for them, I do not propose to express any opinion about those decisions.

Following that decision, the branch initiated proceedings in the BC Supreme Court for judicial review. Oral arguments were made on May 26 to 28, 2008, and Mr. Justice Melnick rendered his judgment on June 24, 2008.[24] In lengthy Reasons for Judgment, he dismissed the branch's application. He concluded that:

- The principle of Crown immunity normally precludes external review of the exercise of prosecutorial discretion, and section 29 of the *Public Inquiry Act* does not indicate an intention by the Legislative Assembly to defeat a claim of immunity.

- The Crown may waive immunity: "Where it is in the public interest to waive immunity and where such a waiver is consistent with the Crown's duty to the public, the immunity can be waived as part of a balancing of these interests. It is for the Crown to weigh competing duties to the public and determine whether the public interest is best served by claiming immunity" (para. 42).

- The Criminal Justice Branch is entitled, subject to waiver, to claim solicitor-client privilege with respect to material relied upon and opinions prepared in connection with coming to the decision that no one would be charged in connection with the death of Mr. Paul.

- The Lieutenant Governor in Council's direction to me to inquire into the "response" of the branch to the death of Mr. Paul is a clear indication in all the circumstances that the Crown was waiving any claim of immunity.

- By personally signing the Order in Council establishing the inquiry's Terms of Reference, the Attorney General was effectively giving the Assistant Deputy Attorney General in charge of the branch a lawful

[24] The judgment is cited as 2008 BCSC 817, and is available at http://www.courts.gov.bc.ca/Jdb-txt/SC/08/08/2008BCSC0817.htm.

binding directive under s. 6 of the *Crown Counsel Act* to waive both immunity and privilege.

- Although the leading judicial authorities addressing the concept of the honour of the Crown were decided in the context of the treaty negotiation process, the concept is not necessarily restricted to those contexts. The honour of the Crown is always at stake in its dealings with Indian people —it is always assumed that the Crown intends to fulfil its promises. If the written expression of the will of the Lieutenant Governor in Council and of the Attorney General has not been effective in waiving both Crown immunity and solicitor-client privilege, the result is manifestly unfair to the general public, the Aboriginal population and the Paul family. The Court added, at para. 67:

  > Because of the Lieutenant Governor in Council's decision to waive Crown immunity, the honour of the Crown demands that the branch waive solicitor-client privilege to enable the Commissioner to review the documents and, if necessary, require those individuals who were then with the branch, and were participants in the response of the branch to the death of Mr. Paul, to give evidence.

- The reference in my Ruling to the branch being "currently under a cloud" was simply a reference to my perception of the concern of some members of the public with the position taken by the branch, and does not in any way create a reasonable apprehension of bias against the branch.

The branch is appealing Mr. Justice Melnick's decision to the BC Court of Appeal. The appeal was heard in December 2008 and Commission Counsel are waiting for the Court's decision.

I accepted the advice of Commission Counsel that, due to these legal proceedings, I should defer any inquiry into the branch's response to Mr. Paul's death. If the final judicial determination is that I have jurisdiction to inquire into some or all of these matters, then I intend to reconvene the evidentiary hearings to hear the prosecutors' evidence. I will also examine, as contemplated by paragraph (e) of the Terms of Reference, the branch's current rules, policies and procedures "related to the role and response of the branch where an individual dies in circumstances similar to the circumstances of Mr. Paul's death." In that event, I will publish a final report, dealing exclusively with issues relating to the Criminal Justice Branch.

C. Policy Issues

1. The Terms of Reference and the issues arising from the evidentiary hearings

When this inquiry began, I extracted three broad policy themes from paragraphs (c) to (g) of the Terms of Reference:

- examining the VPD's and BC Ambulance Service's current policies and procedures respecting their interaction with people who are incapacitated by alcohol or drug use,
- examining the role and response of the BC Coroners Service, the Police Complaint Commissioner and the Criminal Justice Branch when a person dies in circumstances similar to Mr. Paul, and
- identifying the health care and social service programs and facilities that a VPD officer may access when confronted with a person like Frank Paul, who does not need to be detained but who requires immediate health care or social services because he or she is incapacitated by alcohol or drug use.

Put more simply:

- How should police officers and ambulance attendants deal with people like Frank Paul?
- When the police are involved in the death of someone like Frank Paul, how should our public agencies respond?

My understanding of these issues has evolved over the past year, as I listened to witnesses during the evidentiary hearings, read reports about the three intertwined issues of homelessness, addiction and mental illness, and heard from experts in two seemingly unrelated fields—the investigation of police-related deaths and the provision of shelter and services to homeless people who, more often than not, also experience mental illness and/or addictions.

As my understanding of these issues grew, I identified some limitations in the strict wording of the Terms of Reference that I found troubling. I am advised that this is common as public inquiries delve into the tasks assigned to them. Quite understandably, those who draft and approve an inquiry's terms of reference have a general appreciation of the concerns that led to the inquiry being

established, but cannot be expected to anticipate what avenues the inquiry will ultimately pursue based on the evidence that emerges.

This inquiry is no different. I can provide several examples of how my interpretation of my mandate has evolved because of the evidence I have heard and the policy issues our team has explored.

First, police involvement with incapacitated people: paragraph (c) of the Terms of Reference focuses on the VPD's rules, policies and procedures for dealing with people incapacitated by alcohol or drug use, and paragraph (f) invites me to recommend changes that I consider necessary to those rules, policies and procedures. As I will discuss in more detail later in this report, British Columbia has "decriminalized" public intoxication in the sense that chronic alcoholics are no longer charged with an offence for being intoxicated in public, yet we still depend on police officers to respond to such "man down" calls and to arrange for their transport either to a short-term sobering unit, such as the one at the Detox Centre or, if they have a history of violence, to the Jail's sobering cell ("drunk tank"). In either case, the intoxicated person is released back to the streets within a few hours, and the cycle repeats itself with alarming regularity.

Narrowly construed, the Terms of Reference invite me to propose improvements in the VPD's procedures respecting its officers' interactions with such incapacitated people. I have concluded that I cannot do so. During this inquiry, participants have unanimously condemned the current regime. However compassionate individual ambulance attendants and police officers are, the current practice of incarcerating incapacitated people and then releasing them back onto the streets and alleyways of the Downtown Eastside, with inadequate community supports and no assurance of safe accommodation, ignores the problem and must stop immediately.

If I suggest improvements to the VPD's procedures for handling such incapacitated people, I run the risk of perpetuating the current regime, which I will not do. When this inquiry began, my team and I did not foresee the profoundly important social policy issue contained within paragraph (c) of the Terms of Reference. Now that it has clearly emerged, I must interpret my mandate with this new understanding, and address the issue accordingly.

The second instance of how my mandate interpretation evolved over the course of the inquiry arose out of paragraph (g) of the Terms of Reference: the issue of health care and social services for people incapacitated under similar circumstances to those of Mr. Paul. Construed narrowly, the terms invite me to stand in the shoes of a Vancouver police officer who has responded to a "man down" call, and finds a person who is clearly incapacitated by alcohol or drug use. In all likelihood, this officer or others will have dealt with this person many times before. If the attending officer concludes that it is not necessary to detain the incapacitated person for criminal charges or outstanding warrants, but realizes (perhaps with the assistance of ambulance attendants on the scene) that the person is incapable of looking after himself or herself, what health care or social services and facilities are available that will accept someone in this condition? In other words, I am asked to prepare an inventory of current services that the officer can draw on.

As I will discuss in more detail later in this report, the list is very short—the emergency ward of a hospital, the short-term sobering unit attached to the Detox Centre, or the Jail. People so grossly intoxicated (and sometimes violent) are not eligible for admission to other residential detox facilities, or shelters, in the Downtown Eastside.

Police officers are generally aware of what services and facilities they can access in these situations. Merely reciting them in this report would provide no assistance to police officers on the street, and would offer no guidance to our political leaders and policy makers.

What has emerged with resounding clarity during this inquiry is that the way we as a society deal with such incapacitated people is a disgrace, and must change. I have interpreted my mandate in that light. I am confident that a new approach to providing a home and supports for such chronically incapacitated people can be put in place promptly and at less cost than our current dysfunctional non-system, and will restore an element of dignity to their desperate and often troubled lives.

My third example of an evolving mandate interpretation pertains to the investigation of police-related deaths. Paragraph (b) of the Terms of Reference instructs me to examine the response of the VPD to the death of Mr. Paul. The department's response was twofold. Its Major Crimes Section conducted a

criminal investigation to determine the circumstances surrounding Mr. Paul's death. When that investigation was complete and a report had been forwarded to the Criminal Justice Branch, the department's Internal Investigation Section (IIS) conducted a separate investigation into whether any police officers should face disciplinary proceedings for a breach of their professional obligations.

As the facts emerged during the evidentiary hearings, it became clear to me that there were serious inadequacies in both investigations, which I will discuss in more detail later in this report. At a broader policy level, I became persuaded that the current practice of a home police department conducting criminal and professional standards investigations of its own members in a police-related death is permeated with a fundamental conflict of interest. Even when such investigations are conducted rigorously and impartially, a public perception exists that the police should not investigate themselves.

How should I respond to these conclusions? I appreciate that paragraph (c) of the Terms of Reference invites me to recommend improvements in the VPD's policies respecting its officers' interaction with people who are incapacitated by alcohol and drug use, not its investigation of police-related deaths. Yet paragraph (b) clearly places such investigations on my agenda within the context of ascertaining how those investigations were conducted in the Frank Paul case.

After conducting an exhaustive forensic examination of the VPD's investigations into this case, and after reaching conclusions about the inadequacy of investigations, and the fundamentally flawed current practice of a home department investigating its own members in cases of police-related deaths—it would not serve the public interest if I were to then walk away from the important policy issues thus raised.

In closing submissions, counsel for the VPD took the position that statutory reform was beyond this commission's mandate, because the Terms of Reference speak of "rules, policies and procedures" rather than statutory change.[25] The VPD

[25] Final Submissions on Behalf of the Vancouver Police Department and the Vancouver Police Board, paras. 230–34. The VPD, however, took a more nuanced position in its Phase Four Submissions document: "The VPD and Board do not take a position on the sufficiency of the oversight mechanisms in the *Police Act*" (Submissions Regarding Policy on Behalf of the Vancouver Police Department and the Vancouver Police Board, para. 51).

clarified that it took this position not to curtail this commission's important work, but because statutory reform requires consultation with numerous competing stakeholders, beyond this commission's participants. I appreciate this note of caution. I recognize that there are other perspectives—there will always be other perspectives—and I do not pretend to offer the final word on these matters. Nonetheless, I have concluded that the proposed distinction between "policy" and "statutory reform" in this case cannot be maintained; it does not survive scrutiny. Having gathered significant information on, and insight into, the underlying policy issues, I see no realistic conclusion other than to tackle those issues in a meaningful way.

Later in this report I will discuss this issue in more detail, and propose significant changes in the way in which municipal police forces investigate police-related deaths. In doing so, I recognize that these proposals strike at the heart of two important societal values—police independence in the investigation of allegations of criminality, and the need for our police to be subject to civilian overview. Raising these issues triggers many interests, and in the process of formulating public policy it is essential that all relevant interests be voiced. It is my hope that this report will, at the very least, contribute to this conversation.

2. The inquiry's roundtable discussions

Between April 28 and May 8, 2008, the inquiry convened nine days of informal roundtable discussions of the policy issues arising from the Terms of Reference. Those sessions included presentations by the following participants.[26]

- Aboriginal Legal Services of Toronto:
    - The Criminalization of Intoxication in Canada, by Prof. Neil Boyd, Department of Criminology, Simon Fraser University.
    - Extreme Intoxication—An Extreme Medical Problem Among the Homeless, by Dr. Tomislav Svoboda, Seaton House and St. Michael's Hospital, Toronto.
    - The Annex Harm Reduction Program, by Art Manual, Seaton House Hostel Services Unit, Toronto.

[26] Transcripts of presentations and discussions are available on the inquiry's website: http://www.frankpaulinquiry.ca/hearings.php.

    - Hooper Center at Central City Concern, by Sarah Goforth, Director of Recovery and Engagement Services, Portland, Oregon.
- How to Decriminalize Intoxication in Vancouver, a panel discussion with:
    - Insp. John De Haas, VPD,
    - Jim Hauck, Manager, Addictions Services, Vancouver Coastal Health,
    - Ann Livingstone, Vancouver Area Network of Drug Users,
    - Chris Livingstone, Western Aboriginal Harm Reduction Society, and
    - Bill Wong, Manager of Saferide, Vancouver Recovery Club.
- United Native Nations Society—presentations by:
    - Cameron Ward, counsel for the United Native Nations Society,
    - Peter Ritchie, Q.C., Vancouver lawyer, and
    - Dr. John C. Butt, forensic pathologist.
- BC Ambulance Service—presentations by:
    - Douglas Eastwood, counsel for the BC Ambulance Service, and
    - Dr. Jim Christensen, St. Paul's Hospital emergency physician and Vice-President, Medical Programs, for the Emergency Medical Services Commission.
- BC Coroners Service—presentations by:
    - Rodrick MacKenzie, Director of Legal Services and Inquests
    - Norm Leibel, Deputy Chief Coroner, and
    - Terry Smith, Chief Coroner.
- VPD—presentations by:
    - Sean Hern, counsel for the VPD, and
    - Insp. John De Haas.
- BC Civil Liberties Association—presentations by:
    - André Marin, former Director, Special Investigations Unit, Ministry of Attorney General, Ontario, and
    - Gareth Jones, former investigator with the Special Investigations Unit.

- Police Complaint Commissioner—presentation by:
  - Frank Falzon, Q.C., counsel to the PCC.

The inquiry also received from counsel for the UNNS a well-researched written submission (and two large volumes of supporting materials) on the health care and social services currently available in Vancouver for members of the Aboriginal community who may be experiencing homelessness, addictions and/or mental illness, and what additional services and facilities are needed.

D. The Inquiry's Report

1. The report

As stated earlier, this report addresses all aspects of the Terms of Reference except those parts of paragraphs (b), (e) and (f) dealing with the Criminal Justice Branch of the Ministry of Attorney General.

Depending on the outcome of the legal proceedings initiated by the branch, I will prepare a final report dealing exclusively with the Criminal Justice Branch.

Section 28 of the *Public Inquiry Act* establishes the procedures to be followed, after completion of a commission's report.

2. The minister's responsibilities

Section 28 directs a commission to make its report to the minister (in this case the Attorney General), setting out:

- any findings of fact made by the commission that are relevant to the commission's terms of reference, and the reasons for those findings, and
- if required by the commission's terms of reference, any recommendations of the commission.

The minister must submit the report to the Executive Council (Cabinet) at its next meeting. On receiving the report, the Executive Council may direct the minister to withhold portions of the report because of privacy rights, business interests or the public interest. If it so directs, the minister must remove any portions to be withheld and, in the report, identify any withheld portions and, to the extent possible, summarize them.

Following its review of the report, the Executive Council must then direct the minister to lay the report (except any withheld portions) before the Legislative Assembly. The minister:

- must promptly lay the report before the Legislative Assembly if it is in session or will be in session within 10 days of receiving the direction,
- in any other case, must promptly file the report with the Clerk of the Legislative Assembly, and
- must make available to a participant a copy of the report if it includes a finding of misconduct against that participant, or alleges misconduct by that participant.

Section 28(8) is clear that: "A person [which I interpret to include a commissioner] must not release a report of a commission except in accordance with this section."

PART 3—FRANK PAUL'S FINAL DAYS

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Interim Report of the Davies Commission of Inquiry into the death of Frank Paul

A. Introduction

In this part, I will provide as full and complete a record as possible of the circumstances relating to Frank Paul's death, based on the evidence I heard during the evidentiary hearings. I am satisfied that I can arrive at a reasonably complete record of the circumstances of his death, so as to assure the public and Mr. Paul's family as to what occurred. After reviewing the evidence, I will discuss the factual issues and then summarize my conclusions.

B. Background Facts

The intersection of Main and Hastings Streets in Vancouver is infamous as the heart of the Downtown Eastside, an area well known for its poverty, open drug use and drug-dealing. It is often described as being Canada's poorest postal code.

A few doors north of Main and Hastings is the VPD station at 312 Main Street. In 1998, when Frank Paul died, the station also housed the Jail. The Jail served as a holding facility for men and women arrested on criminal charges, usually before their first court appearance.

One area of the Jail also housed people who were found intoxicated in a public place and were unable to care for themselves. Provincial legislation authorized police officers to take such people into custody, and to hold them without charge for their own protection until they were capable of walking out of the facility. Such incapacitated people were usually held for about four or five hours—long enough to recover to the point of being able to care for themselves, but not so long that they would go into withdrawal.[27]

A police sergeant was in charge of the Jail, and was responsible for assessing when an intoxicated person should be admitted and when they should be released. In deciding whether to release, the sergeant's assessment was whether the person was "able to care for himself."

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[27] See, for instance, the evidence of Sgt. Mulder in response to Mr. Rudin's questions: Transcript, Nov. 20, 2007, p. 164 ("Some of the chronic people in the jail, Mr. Commissioner, would get up in the morning with a higher BAC [blood-alcohol content] than we could ever strive to"). See also the evidence of Sgt. Wood, Transcript, Jan. 14, 2008, p. 17.

When VPD officers encountered a person intoxicated in a public place, they had limited options. The officers could leave the person where they were, leave the person with a friend or send the person home. If officers determined that the intoxicated person had to be detained, they would send the person to the Detox Centre or, if the person was considered belligerent or violent, to the Jail.

The Detox Centre (operated by the health authority) was situated about a dozen blocks south of the Jail, on East 2nd Avenue. It had two parts—a voluntary detoxification program, and a sobering unit where intoxicated persons could be given shelter and monitored until they were sober enough to care for themselves. In 1998, the Detox Centre (the term I use in this report for what more properly is the sobering unit) could hold 18 people in about six rooms.[28] Patients were brought in either by the police or Saferide.[29] The entrance to the Detox Centre's sobering unit was at the end of an alleyway. Frank Paul's body was found at the entrance to this alleyway, about half a block from the sobering unit entrance.

Saferide is a free, safe transportation service to the Detox Centre provided for clients with alcohol and drug problems, run by the non-profit Vancouver Recovery Club. As witness Barry Conroy described, the idea behind Saferide is to free up ambulances and police wagons by stepping in to offer transport to intoxicated people who do not have to go to the hospital or the Jail.[30] Saferide staff carry police radios so that they can be summoned to attend at "man down" calls.

C. The Events of December 5, 1998

December 5, 1998, was the last day in Frank Paul's life—he was found dead early the following morning. In this section, I will describe what happened on Mr. Paul's last day, including his arrest in the morning, his detention in the Jail, his release from the Jail and walking out, his subsequent arrest and his arrival at the Jail where he was refused entry.

1. Frank Paul's first arrest at 11:00 a.m.

James Douglas, a paramedic with the BC Ambulance Service, testified that he and a second attendant responded to a "man down" call at 420 Abbott Street in the

[28] Evidence of C. Low, Transcript, Nov. 26, 2007, pp. 79–82.
[29] There were other service providers who dealt with those found intoxicated in a public place. Emergency Health Services (the Ambulance Service) was usually the first to respond to a "man down" report. Evidence of F. Grossling, Transcript, Nov. 23, 2007, p. 64.
[30] Transcript, Nov. 16, 2007, pp. 5–6.

Downtown Eastside at about 9:45 a.m. on December 5, 1998. When they arrived, they found Mr. Paul[31] sitting against a building. He waved them away, stating: "I'm okay." After assessing him and finding nothing of medical significance, Mr. Douglas offered to drive Mr. Paul to the Detox Centre. Mr. Paul refused, and then got up and walked away, using the wall of the building to do so.[32]

Just before 11:00 a.m., VPD Csts. Timothy Houchen and John Butler went to 404 Abbott Street in response to a 911 call. They found Mr. Paul sitting in an alcove. He was on the ground and wasn't able to stand up.[33] They received information that Mr. Paul had been panhandling and harassing residents of the building. Both officers had no difficulty in determining that Mr. Paul was drunk, from his slurred speech and glassy eyes, and from the fact that he reeked of alcohol. In his testimony, Cst. Houchen described him as belligerent.

Cst. Houchen recalled that Cst. Butler checked Mr. Paul's name on the Canadian Police Information Centre (CPIC) database, which described him as a "caution violent." Cst. Butler knew Mr. Paul from past dealings, and knew that on occasion he would try to punch or kick officers.[34] A police wagon was summoned. The officers stood Mr. Paul up, searched him, and helped him get to the wagon. According to Cst. Houchen, the decision was made to detain him for being intoxicated in public and to take him to the Jail rather than the Detox Centre because of his belligerent nature and his criminal past.[35]

Surveillance cameras were in place at the Jail in 1998. Images from these cameras were played during the evidentiary hearings and entered as exhibits. We are fortunate to have them, as they serve as an impartial and inarguable witness to events that occurred in the Jail. The cameras document events in the wagon-bay area, and also on the fifth floor of the Jail—the booking area.[36] I will sometimes refer specifically to what has been referred to in the video, although in

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[31] Early in our hearings there was some question as to the ambulance attendants' knowledge of Mr. Paul's name; see, for instance, Transcript, Nov. 16, 2007, p. 114. It soon became apparent that the man dealt with by the ambulance was the same man who remained in the area and was arrested by police officers about one hour and 15 minutes later.
[32] Transcript, Nov. 16, 2007, pp. 85–86.
[33] Evidence of T. Houchen, Transcript, Nov. 19, 2007, pp. 8–11; evidence of J. Butler, Transcript, Nov. 21, 2007, pp. 140–44, 151–52.
[34] Transcript, Nov. 21, 2007, pp. 144, 148–49.
[35] Transcript, Nov. 19, 2007, pp. 12–17.
[36] Exhibit 150; Transcript, Feb. 26, 2008, pp. 4–10.

other places I may rely on those images to describe things without stating so explicitly.[37]

I was also well served by Commission Counsel's discovery of audio recordings taken from microphones within the video cameras, and also from a microphone located at the Jail booking desk where admissions were processed. Although only partially comprehensible and difficult to make out, these recordings were a valuable check against the evidence of the witnesses and supplemented the objective evidence of the videotape images.

When Mr. Paul arrived at the fifth floor of the Jail, Corrections officers Janet Ross and Tony O'Buck dealt with him. He was not aggressive or belligerent with them.[38] His outer clothing was wet. They removed his wet clothing and shoes. Then they dragged him on his back, with each officer holding one arm, into a cell set aside for intoxicated people.[39]

Because Mr. Paul was not coherent on arriving at the Jail, the officers did not formally book him in. Janet Ross checked on him about four hours later. She found that he still could not stand readily, even though he was awake and responsive, so she chose to leave him there a while longer. At about 5:00 p.m., when he was able to stand, walk and answer questions lucidly, he was formally booked in.[40] Mr. Paul was detained for roughly six hours and, during that time, assuming that normal protocols were followed, the Jail staff would have checked on him every 15 minutes and a nurse would have checked on him hourly.[41]

2. Frank Paul's release at about 5:00 p.m.

Sgt. Richard Mulder made the decision to release Mr. Paul. He knew Mr. Paul from previous occasions when he had been arrested for intoxication in a public place. He testified that it was easy to tell whether Mr. Paul was intoxicated, from his inability to walk and his incoherence. At around 5:00 p.m., Sgt. Mulder

[37] Technically it is not a "videotape" as it does not show motion the way a movie would, with many frames per second giving a "real-life" fluidity of movement. Instead, these "videotapes" show a series of photographs, each taken every few seconds, so that the movement is jumpy, and some subtleties of physical movement are lost. On this point, see the evidence of Cst. Brett Hallgren of the VPD's Forensic Video Analysis Unit: Transcript, Feb. 26, 2008, especially pp. 4–12.
[38] Transcript, Nov. 20, 2007, p. 23.
[39] Evidence of J. Ross, Transcript, Nov. 19, 2007, pp. 161–75; and Transcript, Nov. 20, 2007, p. 13.
[40] Transcript, Nov. 19, 2007, p. 179; and Exhibit 9.
[41] Evidence of J. Ross, Transcript, Nov. 19, 2007, pp. 174–76.

roused Mr. Paul and had a conversation with him, which led him to conclude that Mr. Paul was "able to fend for himself" and so could be released.[42]

During his testimony, Sgt. Mulder was asked what he would look for in determining whether a person arrested for intoxication was capable of looking after himself and therefore appropriate to release:

> Q What's involved in that assessment, who does it?
>
> A The nurse and/or the jail sergeant.
>
> Q And what do they do?
>
> A They basically see if the individual is coherent, able to look after himself fundamentally, and it's kind of a requirement for release.
>
> Q Okay. Who makes the decision as to release?
>
> A That would be the jail sergeant's call....
>
> Q What do you mean by coherent?
>
> A Able to understand the requests being made of them. Able to have some motor skills....
>
> Q In terms of their motor skills, again what sort of things are you looking for there in terms of a person's motor skills?
>
> A Ability to move on your own. You know, that's basically the biggest, I guess.
>
> Q Okay. And why are you paying attention to their ability to move on their own?
>
> A Well, a lot of time the reason for them being there is their inability to function and to walk or to, you know, convey their body from one point to another. So for them to be able to like, you know, function on their own once they're free of the jail is critical.[43]

3. Frank Paul's departure from the Jail sometime after 6:30 p.m.

After Mr. Paul was released from the Jail, he took the elevator down to the ground floor. A Jail surveillance camera captured him as he walked out of the elevator into the loading bay area. He initially stood, as he put on his outer clothing (which the Corrections officers had returned to him). He then sat down to put on his shoes, a difficult task for him.

[42] Transcript, Nov. 20, 2007, pp. 93–95.
[43] Transcript, Nov. 20, 2007, pp. 85–87.

Linnett McKenna (Linnett Johnson in 1998), a relief police custodial guard in the Jail, saw Mr. Paul sitting in the wagon bay, and she asked him how he was. He asked her for a cup of coffee. She went upstairs, got changed for the start of her shift and, at about 5:30 p.m., brought him a coffee from the kitchen.[44]

When Sgt. Mulder left the Jail, which he believed was at about 6:30 p.m. at the end of his shift, he saw Mr. Paul leaning against the wall in the loading bay (at street level by the back alley), eating chips and drinking a coffee.[45]

Cst. Elizabeth Prince saw Mr. Paul, just before he got up and left the wagon bay. She recalled Mr. Paul asking for some change and she gave him a two-dollar coin. She saw him edge along the wall as he left the loading bay area.[46] In her written statement, prepared several weeks later, Cst. Prince described Mr. Paul as being "in bad shape" with "a gnarled hand and unable to fully function." His shoes "were pushed down at the heel like a pair of slippers and no socks."[47] The videotape also shows him using the wall to stand, and relying on the wall for balance.[48] There is some discrepancy as to the precise time when Mr. Paul left the wagon bay area. This is understandable, as witnesses relied on their recollection of when they left or arrived at the building that day. While I cannot be precise, I have concluded that it was shortly after 6:30 p.m. that Mr. Paul departed, based on the timing of his release by Janet Ross and the length of time he is shown on the Jail video in the wagon bay area.

4. Frank Paul's second arrest at 8:00 p.m.

Csts. Robert Turner and Derek Peterson were working together the evening of December 5. At about 8:00 p.m., they observed a man on the sidewalk at the corner of East Hastings and Dunlevy Streets, in the Downtown Eastside, about two blocks east of the Jail. They identified the man as Oscar Angel. He was very heavily intoxicated.[49] Cst. Peterson dealt with Mr. Angel. He described him as unable to walk on his own and hard to understand because of his level of

[44] Transcript, Nov. 29, 2007, pp. 168–73.
[45] Transcript, Nov. 20, 2007, p. 107.
[46] Transcript, Nov. 19, 2007, pp. 190–91.
[47] Exhibit 11. The videotape and autopsy photographs confirm that he had two or more pairs of socks on his feet.
[48] This description is consistent with the evidence of parathesia, which is caused by Wernicke-Korsakoff Syndrome.
[49] Transcript, Nov. 26, 2007, pp. 145–46 (R. Turner).

intoxication, although he was non-violent and responsive. They called for a police wagon, to take him to the Detox Centre.[50]

Meanwhile, Cst. Turner noticed Frank Paul:

> ... I noticed another male on Dunlevy Street at Hastings on the west side of 400 Dunlevy. He was lying on the vegetable stand outside a closed store with an awning over top.... That male appeared to be sleeping on the vegetable stand.[51]

Cst. Turner approached him, shook his shoulder and asked him for his name. He said the man was incoherent, his speech was slurred and unintelligible, but he did give his name as Frank Paul. When Cst. Turner asked, "Have you had too much to drink tonight? Where are you sleeping? How long have you been here?" he was unresponsive. Cst. Turner smelled rice wine on Mr. Paul's breath and described him as "clearly intoxicated."[52] He testified that he was "100 percent convinced he was intoxicated." Cst. Turner described the weather that evening as a mixture of rain and snow.[53]

A police wagon, driven by Cst. David Instant, arrived at the scene. Cst. Instant was a probationary constable who had been a member of the department for just five months. Cst. Turner told Cst. Instant that Mr. Paul was to go to the Jail and that Mr. Angel was to go to the Detox Centre.[54]

Cst. Turner testified that, given his previous dealings with Mr. Paul, he was aware that Mr. Paul could be belligerent and could present "a bit of a problem when he's been drinking." He believed that CPIC showed that Mr. Paul could be violent. However, he agreed that on this evening Mr. Paul was neither belligerent nor violent. Cst. Turner's understanding was that if someone had been considered violent at one time, they should not go to the Detox Centre.[55]

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[50] Transcript, Nov. 27, 2007, pp. 130–34.
[51] Transcript, Nov. 26, 2007, p. 146.
[52] To similar effect, Cst. Peterson testified that it was obvious Mr. Paul was intoxicated: "there was absolutely no doubt": Transcript, Nov. 27, 2007, p. 138.
[53] Transcript, Nov. 26, 2007, pp. 146–55 (quotation p. 155).
[54] Transcript, Jan. 9, 2008, pp. 173–74.
[55] Transcript, Nov. 26, 2007, pp. 159–65; see also evidence of Cst. Peterson, Transcript, Nov. 27, 2007, p. 135; and evidence of Cst. Instant, Transcript, Jan. 9, 2008, pp. 174–75.

Csts. Turner, Peterson and Instant all helped lift Mr. Paul into the rear compartment of the police wagon. According to Cst. Turner, Mr. Paul was "not able to walk that night"; he could not move on his own and had to be carried to the police wagon.[56]

Cst. Instant testified that Mr. Paul was a dead weight, and did not engage in any conversation. Once loaded into the wagon, Cst. Instant queried Mr. Paul's name on CPIC, and saw that he had a criminal record and there was a caution that he could be violent. He drove directly to the Jail. On arrival, he collected his gear and donned rubber gloves before opening the rear compartment door. He said, "Frank, we're here. Time to get out." Mr. Paul did not move; he was lying on his back with his head towards the door. He made a bit of a mumble sound but did not do anything more. Cst. Instant grabbed him by his shoulders and pulled him out of the wagon. He dragged him to the elevator in the wagon bay.[57]

Cst. Instant noticed that Mr. Paul was wet in the crotch area and on his thighs, but he did not notice wetness on his upper clothing. He thought Mr. Paul might have become wet when he pulled him out of the wagon and onto the ground.[58]

Counsel for the United Native Nations Society introduced into evidence photographs of the asphalt surface behind the Jail, which showed that water did puddle outside the wagon bay doors and that, accordingly, it is probable that the wet trail seen on the videotape being left behind by Frank Paul occurred, in part, because he had just been dragged through standing water before entering the wagon bay.[59]

Cst. Instant testified that he believed Mr. Paul was drunk and unable to care for himself.[60]

5. Frank Paul's arrival at the Jail

In this section, I will discuss the evidence given by three important witnesses, Cst. Instant, Sgt. Sanderson, and Corrections Officer Greg Firlotte. Each of them

[56] Transcript, Nov. 26, 2007, pp. 157–59; see also evidence of D. Peterson, Transcript, Nov. 27, 2007, p. 134.
[57] Transcript, Jan. 9, 2008, pp. 175, 178–81.
[58] Transcript, Jan. 9, 2008, pp. 182–84, 188; Transcript, Jan. 11, 2008, p. 65.
[59] Exhibit 77.
[60] Transcript, Jan. 9, 2008, p. 185, and Transcript, Jan. 11, 2008, pp. 65–66.

gave written statements soon after the discovery of Frank Paul's body, and they also testified during the evidentiary hearings. I will set out their written statements verbatim,[61] and then summarize their testimony.

a. Written statements

Cst. David Instant

98-12-05 @ 20:19 hrs., PC 1855 INSTANT attended E. Hastings at Dunlevy to transport a male to VPD Jail for state of intoxication in a public place. Arrest for SIPP[62] conducted by PC 1703 PETERSON i/c PC 1694 TURNER. PC's placed male, known to PC 1703 i/c[63] PC 1694 as Frank PAUL into police wagon.

98-12-05 @ 20:21 hrs., PC 1855 attended VPD Jail, 5th floor, elevator door opened and discussion with Jail N.C.O. SANDERSON occurred. N.C.O. advised that PAUL had just been released from Jail at 18:30 hrs. on 98-12-05. PAUL suffers from condition where he acts in a manner similar to that as being intoxicated. PAUL is a person of NFA[64] and resides on the street. PAUL indicated he has not had a drink for 3 days and was not intoxicated. Jail N.C.O. authorized a transport out of area on a breach. PC advised Ch 2 to change SIPP to a breach. PC 1855 transported PAUL to south lane of 300 blk. E. 1st where PAUL was released from custody (98-12-05 @ 20:51 hrs.).[65]

Sgt. Russell Sanderson

At approx. 17:30 hours on 98DEC05 the u/s[66] attended to the VPD Gaol to start shift. On arrival in the wagon bay the u/s found a recently released prisoner, PAUL, Frank Joseph sitting on the concrete across from the elevator. PAUL was sitting against the wall eating what appeared to be some sort of potato chips. PAUL is well known to the gaol staff as being a chronic alcoholic who has a great deal of difficulty even standing when sober. At approx. 18:15 hrs PCG 9502 Johnson gave a large cup of coffee to PAUL. Who was still sitting in the wagon bay. PAUL was conscious and said thanks for the coffee.

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[61] Their verbatim statements represent the first recording of information by each of these men. In Cst. Instant's case, it was soon supplemented by a longer "duty report" prepared with counsel. They have additional relevance in that they illustrate the nature and extent of the information provided by way of the written reports, which in the case of these three men was not explored by way of an interview or otherwise.

[62] Hold/State of Intoxication in a Public Place.

[63] In the company of; together with.

[64] No Fixed Address.

[65] Exhibit 74.

[66] The undersigned, i.e., Sgt. Sanderson.

Approx. 20:00 to 21:00 hours PAUL was again brought into the gaol by wagon 2E62 driven by PC 1855 Instant. The u/s met the wagon driver in the elevator and stated that there was no way that PAUL was intoxicated but that he was debilitated to the extent that he was slow moving and passive when sober. PAUL was communicative and stated that he lived in the area of West Broadway and Maple Street. The u/s could not confirm this fact as PAUL was booked in as NFA. PAUL's condition did not appear any different to his usual state of post gaol stay sobriety. The u/s requested that the wagon driver take PAUL and drop him off in the area of West Broadway and Maple (his stated home). Corrections member 20401 Firlotte assisted the wagon driver in placing PAUL into the wagon.

PAUL was originally arrested on 98DEC05 @11:20 hours at 404 Abbott Street (see incident number: 98-285166). He was released from custody at 17:05 hours by Corrections member 01736 Ross.[67]

Corrections Officer Greg Firlotte

At approx. 17:30, I entered the loading bay at VPD, to take the elevator, to the 5th floor to begin my shift, at the jail. It was in the loading bay, I noticed Frank PAUL, sitting off to the side, drinking a coffee and eating some chips. Frank PAUL, was known to myself, from my two months of relief duty, at city cells. Mr. PAUL, was coherent, as we talked about the rain, as I waited for the elevator. I assumed that Mr. PAUL, had probably just been released from upstairs, as he usually came in a couple times a week, as a H/SIPP. At approx. 20:30–21:30 hrs., later that evening I noticed one of the male PC wagon drivers, bring Mr. PAUL out of the elevator, Mr. PAUL had difficulty standing, and was laid on the floor, as the jail staff spoke with Mr. PAUL, it was noted that he was coherent and did not appear drunk. Mr. PAUL confirmed this. The decision was made to return Mr. PAUL, to his place of residence, via the wagon, as he had problems walking and because it was raining. I assisted the wagon driver in bringing Mr. PAUL to the wagon, helped place him in the wagon and returned to the fifth floor. Mr. PAUL appeared alert and coherent and not under the influence of alcohol. This observation is based solely on my experience in dealing with Mr. PAUL, in that two month secondment at VPD jail. It should be noted the Mr. PAUL, had problems being mobile and used a cane.[68]

[67] Exhibit 59.
[68] Exhibit 44.

b. Testimony during evidentiary hearings

Cst. David Instant

Cst. Instant testified that he dragged Mr. Paul into the elevator, positioning him so that he was lying on his back on the floor with his feet toward the door of the elevator. He said that Mr. Paul's position remained the same throughout his time in the elevator.[69] His clothing was not altered. He was not searched.[70]

Cst. Instant testified that when the elevator door opened at the Jail, he saw Sgt. Sanderson, the sergeant in charge of the Jail that night. Sgt. Sanderson, standing a few feet back from the elevator door, said: "What do you have there?" Cst. Instant said he had Frank Paul for being intoxicated. Sgt. Sanderson entered the elevator and said: "There's no way that Frank's drunk. We just released him at 6:30."

Sgt. Sanderson stood by Mr. Paul. Cst. Instant testified that he told Sgt. Sanderson: "He was found laying on a vegetable rack at Dunlevy and Hastings," to which Sgt. Sanderson responded: "He's homeless. That's where he sleeps." Cst. Instant replied, "Well he can't even walk." Sgt. Sanderson advised that he could walk, but had a disability making him slow moving: "It takes him a while to get up and underway." He added: "When we released him, it took him a half hour to get himself up and out of the bay."[71]

Cst. Instant testified that Sgt. Sanderson asked Mr. Paul if he'd been drinking, and Mr. Paul made a sound, mumbling "no, no." He recalled Mr. Paul saying something about not drinking for three days. Cst. Instant did not give much credence to this, because he appeared drunk. Sgt. Sanderson continued to stand over Mr. Paul, looking at him. He then advised Cst. Instant that Mr. Paul was not drunk, and in fact, had a condition that made him appear to be drunk, when instead he was just slow-moving and lethargic and passive.

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[69] This is consistent with the video, which shows Mr. Paul's position when Cst. Instant brought him into the Jail, and his position on being brought back down to the wagon bay. The position is the same.
[70] Transcript, Jan. 9, 2008, pp. 189–90.
[71] Transcript, Jan. 9, 2008, pp. 191–94.

The sergeant then asked Mr. Paul where he lived. Cst. Instant recalled Mr. Paul saying "Broadway" but could not understand what else he said. Sgt. Sanderson advised that this was Broadway and Maple, and then moved back to talk with booking staff to confirm the address. Cst. Instant understood that they could not confirm this, and that Mr. Paul had previously been booked as "NFA"—no fixed address.[72]

Cst. Instant then asked Sgt. Sanderson what he should do with Mr. Paul; should he breach him?[73] Sgt. Sanderson said yes, take him to Broadway and Maple. Cst. Instant felt he had the authority to "breach" someone on his own, but was asking for some direction as to where to go. His understanding was that Broadway and Maple was "the location or the best guess as to the area in which Mr. Paul may live on the street."[74]

Cst. Instant did not have any further discussion, nor did he seek further direction:

> I was confused by it. It was something that I didn't see coming. I took him there for being—for being drunk and then I'm advised by an experienced sergeant of the jail that, in fact, what I'm seeing is not this man being drunk and, in fact, this is just a condition that he has where he appears drunk. So it was—it was a little confusing.[75]

Cst. Instant testified that, if he had felt medical attention was needed, he would have suggested it. However, Sgt. Sanderson appeared to know Mr. Paul very well, and he relied on the sergeant's observations and experience.[76]

Cst. Instant and Corrections Officer Greg Firlotte took Mr. Paul down in the elevator. At the wagon bay, they each took an arm and pulled him to the wagon. Mr. Paul remained motionless and silent, with his eyes open. He was placed in the side compartment of the wagon.[77] The videotape

[72] Transcript, Jan. 9, 2008, pp. 194–96.
[73] A "breach of the peace" refers to the police policy of detaining and transporting a troublemaker from one area of the city to another, in order to prevent or remedy a breach of the peace. For a handy description, see the evidence of R. Turner, Transcript, Nov. 26, 2007, p. 166.
[74] Transcript, Jan. 9, 2008, pp. 196–98.
[75] Transcript, Jan. 9, 2008, pp. 199–200.
[76] Transcript, Jan. 9, 2008, p. 203.
[77] Transcript, Jan. 9, 2008, pp. 205–09.

does not show the officers placing Frank Paul in the wagon but does show the wagon itself. This time recording shows that several minutes passed after Frank Paul was taken out of the wagon bay before the wagon drove away.

Sgt. Russell Sanderson

Sgt. Sanderson was in charge of the Jail that night. He had been with the department for 18 years. He had been a Jail sergeant since April 1998. The training to become a sergeant involved a promotional exam, and training to be the Jail sergeant involved about one week of working alongside an existing Jail sergeant.[78]

Sgt. Sanderson testified that, as Jail sergeant, he bore the ultimate responsibility for determining whether a person could be held under the VPD's H/SIPP (Hold/State of Intoxication in a Public Place) policy. He could recall a few occasions when someone might be arrested H/SIPP but not admitted to Jail on that basis.[79]

When asked about handling prisoners, he said it was not unusual to drag a prisoner who was unable to walk, and that this was done for the person's safety, to prevent a fall and injury.[80]

Sgt. Sanderson knew Mr. Paul, who was in jail every second or third day as an H/SIPP arrest. On most occasions, Mr. Paul would be unconscious or virtually unconscious, and unable to answer questions. He said Mr. Paul had a tendency to be violent. Although Sgt. Sanderson testified that he did not know about Wernicke-Korsakoff Syndrome or its symptoms, he described Mr. Paul's ability to move about as follows:

> Mr. Paul always had difficulty walking. Most of the time he would—I use the expression "crab" along the wall. He would use the wall for support as he moved along it.[81]

[78] Transcript, Jan. 7, 2008, pp. 30–33.
[79] Transcript, Jan. 7, 2008, p. 46.
[80] Transcript, Jan. 7, 2008, p. 49.
[81] Transcript, Jan. 7, 2008, pp. 50–52 (quotation p. 52).

Sgt. Sanderson first saw Mr. Paul that day at about 5:30 p.m., as he arrived for work. Mr. Paul was sitting on the floor of the wagon bay, against the wall opposite the elevator, eating a bag of potato chips. At about 6:15 p.m., a Jail staff member asked for permission to take Mr. Paul a cup of coffee. He gave permission, and the staff member took "a large scalding hot cup of coffee" to Mr. Paul.[82]

Sgt. Sanderson next saw Mr. Paul sometime between 8:00 and 9:00 p.m., when Jail staff alerted him that Mr. Paul was in the elevator as it arrived on the fifth floor. Sgt. Sanderson said there was "a disbelief" that Mr. Paul would be back in custody so soon, and he shared that disbelief. He said he asked Cst. Instant why he had brought Mr. Paul to the Jail, and Cst. Instant replied that he was arrested H/SIPP. Sgt. Sanderson said:

> I found it extremely difficult to believe that, as I said, that Mr. Paul was actually intoxicated and therefore he should not have been arrested.

According to Sgt. Sanderson, Mr. Paul had difficulty getting around. He "would not be sprinting to the nearest liquor store," and Mr. Paul usually did not have any money. He said that it would be difficult for him to get to a licensed premise for alcohol, and that those places selling rice wine would be closed sometime between 5:00 and 6:00 p.m.[83] For these reasons, he concluded that Mr. Paul could not have gotten intoxicated in the period of time since he left the Jail. He testified:

> Q Can you compare how he looked when he was in the elevator as to how you had seen him at the beginning of your shift?
>
> A His appearance hadn't changed markedly at all. His outer clothing was wet but he appeared to be in the same state as my observations of him in the wagon bay at the beginning of the shift.[84]

Mr. Paul remained lying in the elevator while it was at the fifth floor. While there, Sgt. Sanderson asked him if he'd had anything to drink since

[82] Transcript, Jan. 7, 2008, pp. 53–54 (quotation p. 54). It is not clear how the sergeant knew how hot the coffee was. The officer who brought the coffee, Linnett McKenna (Johnson), recorded in her written statement that it was hot but had both sugar and cream: Exhibit 51.
[83] Transcript, Jan. 7, 2008, pp. 55–57 (quotation p. 56).
[84] Transcript, Jan. 7, 2008, p. 57.

being released from jail, to which Mr. Paul answered: "no." He described the response as being immediate, in a quiet, gruff, hoarse voice that might be hard to understand if heard for the first time. He described Mr. Paul's manner of speech as being the same as he would speak when being released from the drunk tank.

The sergeant said he asked where he lived, and Mr. Paul replied "Broadway and Maple." Sgt. Sanderson had some knowledge of "a group of Aboriginal males that frequented that area," and said that he believed Mr. Paul had a place where he could go "to get out of the elements, whether it was his home or just the home of an associate." He did not ask whether Mr. Paul had an address, nor did anyone else.

Sgt. Sanderson testified that, although the decision to admit or release Mr. Paul was his, he would take advice and comments from the Jail staff and that, in this case, there was a general consensus that Mr. Paul was not in fact drunk.[85]

Sgt. Sanderson agreed that, during Mr. Paul's time in the elevator, nobody asked him how he was feeling, if he was cold, whether he could move his hands or legs, why he appeared unable to move or whether he wanted to see a nurse.[86] The entirety of Sgt. Sanderson's assessment of Mr. Paul took place within three minutes, while Mr. Paul was in the elevator.[87]

Sgt. Sanderson felt that the "easiest way" was to send Mr. Paul to the ground floor and have him released into the alley behind the Jail. However, it was raining and a wagon and driver were on hand, and he thought it would be "much better for Mr. Paul to take him to where he stated that he lived so that he could find shelter and get out of the elements." Sgt. Sanderson stated that he reasoned there were no other good options; Frank Paul was not intoxicated so would not go to Detox

[85] Transcript, Jan. 7, 2008, pp. 60–63, 69–71.
[86] Transcript, Jan. 8, 2008, p. 77.
[87] Transcript, Jan. 8, 2008, p. 80.

Centre, and moreover, Sgt. Sanderson believed he was banned from there.[88]

This is what the sergeant said he expected would occur when the wagon got to Broadway and Maple:

> I expected Cst. Instant to take him to that area, open the wagon door and ask Mr. Paul if this was in fact the area where he lived and obtain further directions, ensure that, if necessary, driving him half a block closer to his residence or whatever it called for, and release Mr. Paul and ensure that he was well on his way or in shelter before leaving.

He continued:

> Unfortunately, my instructions were quite vague. I asked Cst. Instant to take Mr. Paul to Broadway and Maple. I did not give him any further specific instructions. He had listened to what was going on in the elevator and I assumed that he would understand what to do.[89]

Sgt. Sanderson testified that, with the benefit of hindsight, he should have been more specific and should have ensured that Cst. Instant would contact a senior officer or himself if he needed further instructions.[90] However, he stood by his decision not to admit Mr. Paul to the Jail, and believed that it was the correct decision.[91]

Sgt. Sanderson testified that he did not consider Mr. Paul a "breach of the peace" situation, but said that he agreed to Cst. Instant's request to have the matter treated as a breach, to keep it within departmental policy.[92]

Corrections Officer Greg Firlotte

Corrections Officer Firlotte was working as the floor security officer at the Jail that night. He was new to the job. He recalled being surprised to see

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[88] Transcript, Jan. 7, 2008, pp. 71–72. There is no evidence, including in the audiotape, that indicates Sgt. Sanderson verbalized this belief with anyone, including Cst. Instant, at this juncture. I will return later in the report to the question of whether Mr. Paul was banned from the Detox Centre. For present purposes I observe that he was admitted there many times in the weeks previous to his death, including on December 4, 1998. Also, Sgt. Sanderson's insistence that Mr. Paul was not intoxicated, and therefore could not remain at the Jail, would also rule out the Detox Centre as a place to leave him.
[89] Transcript, Jan. 7, 2008, pp. 72–73.
[90] Transcript, Jan. 7, 2008, p. 73.
[91] Transcript, Jan. 7, 2008, p. 86.
[92] Transcript, Jan. 7, 2008, pp. 74–75; Transcript, Jan. 8, 2008, pp. 128–37.

Mr. Paul when the elevator door opened, having seen him in the wagon bay just two hours before. He recalled a discussion about Mr. Paul, and believes he asked, "Why is he here? [H]e just left."

He stated that Mr. Paul was lying down in the elevator throughout.[93] He believed he helped to prop Mr. Paul up against the wall inside the elevator. He recalled that Mr. Paul was soaking wet, that he did not talk (although he did respond with a grunt or groans), and that he was awake and his eyes were open.[94] He agreed that Mr. Paul appeared oriented as to time and place.[95]

He stated that Sgt. Sanderson took a look at Mr. Paul and decided to release him out of the Jail. Mr. Firlotte went back to the elevator and told Mr. Paul, "Okay, you're out of here," and gave him back his jacket and shoes. He recalled that Mr. Paul could move his hands but not his legs. He stated that there was some discussion about where Mr. Paul lived, and Mr. Firlotte recalled Mr. Paul saying: "2nd and Nanaimo." He understood Mr. Paul was being sent back out, and that Mr. Paul would be dropped at his address. He said there was no discussion of an ambulance and the Jail nurses, who were available, were not called.[96]

Mr. Firlotte assisted Cst. Instant in dragging Mr. Paul out of the Jail. They dragged him along the floor of the wagon bay out to the wagon. He testified that he climbed into the wagon and then pulled Mr. Paul up and put him in the wagon, propping him up so that his back was against the wall. He then gave him his jacket and his shoes, which had been taken from him in the elevator.[97]

Mr. Firlotte's evidence presented numerous difficulties. He initially misidentified the sergeant who dealt with Frank Paul that evening. He initially indicated that the wagon driver removed Mr. Paul from the elevator at the fifth floor of the Jail but he agreed, after seeing the Jail

[93] Before seeing the video, Mr. Firlotte believed he had moved Mr. Paul out and propped him up against a wall; the video showed him this did not occur: Transcript, Nov. 28, 2007, p. 11.
[94] Transcript, Nov. 28, 2007, pp. 6–15.
[95] Transcript, Nov. 28, 2007, p. 101.
[96] Transcript, Nov. 28, 2007, pp. 16–27.
[97] Transcript, Nov. 28, 2007, pp. 27–35.

video, that this did not occur. He used language in his statement suggesting that Mr. Paul had difficulty standing and was laid on the floor, but accepted that this was not accurate, as Mr. Paul was never laid down on the floor from a standing position; he was already lying down.[98]

In his initial statement, Mr. Firlotte stated that Mr. Paul was "coherent and did not appear drunk," and that he was "alert."[99] Although it was suggested to him (and he accepted) that he used the term "coherent" in the alternative dictionary sense of being sensible, the context of the term in his statement seems only explicable as suggesting Frank Paul was speaking with sense and meaning that evening. He later accepted that this did not accord with his testimony, but he could not provide an adequate explanation for the difference.[100]

Further, Mr. Firlotte initially denied that a VPD detective had contacted him to provide a statement. However, when confronted with evidence suggesting the opposite, he seemed to imply that the detective's log notes were faked.[101] This testimony did not strengthen his credibility.

c. Other witnesses' testimony

Corrections officer Michelle Renville was on duty when Cst. Instant brought Mr. Paul to the Jail. She recalled hearing that an intoxicated man was being brought in.[102] She said:

> I remember the officer standing there with the man and other officers coming around and taking a look at him, and I remember someone saying that he can't be intoxicated, he had just left, and he had just left out of the drunk tank.[103]

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[98] Transcript, Nov. 28, 2007, pp. 41, and 103–05. In his original written statement, he indicated that Mr. Paul "did not appear drunk": Exhibit 44. His explanation for the use of the word "drunk" was to the effect that Mr. Paul was always that way when he dealt with him. "To me, I guess drunk for Mr. Paul would be passed out" (p. 103). But Mr. Firlotte described Mr. Paul as having no mobility; it is difficult to understand the meaning he attributes to "not being drunk."
[99] Exhibit 44.
[100] Transcript, Nov. 28, 2007, p. 42.
[101] Transcript, Nov. 28, 2007, p. 129 (and generally pp. 123–31).
[102] Transcript, Nov. 20, 2007, p. 191.
[103] Transcript, Nov. 20, 2007, p. 195.

She was not sure who was present at the time, other than Greg Firlotte, whom she recalled being there. She added:

> I think I just remember them talking, saying that Mr. Paul was a frequent inmate in the drunk tank, and they had said that when he had been released earlier he couldn't have gotten, you know, like far to be drunk enough to come back in that intoxicated state.[104]

She recalled Mr. Paul lying down, with officers holding him up by his shoulders. She recalled the sergeant asking him where he lived, and Mr. Paul saying "Kitsilano." This surprised her, because she considered it an upscale neighbourhood. She did not recall hearing an address mentioned. She did not recall discussion of a breach. She said Mr. Paul's eyes were open, his clothes were wet and when he was moved, he left a water trail.[105]

Ms. Renville's recollection of some of the events that evening disagreed with the video evidence. However, I found her to be a credible witness who was honestly attempting to give me her best memory of the events she witnessed many years ago.

Kenneth Low was a police custodial guard in 1998, and was on duty when Mr. Paul was brought to the Jail that evening. Unfortunately, Mr. Low's recollection of events was demonstrably wrong.[106] His recollection was that Mr. Paul left at 2:00 a.m. on December 6, and he thought he had checked in on him after he was arrested just behind the Jail. Mr. Low readily accepted, after seeing the Jail videotape, that his memory was in error. It is understandable that with the passage of many years, a person's memory of a particular shift at work may not remain with any great clarity. What is unfortunate is that no one asked Mr. Low for a statement or interview, until Associate Commission Counsel did in late 2007.[107]

Police custodial guard Linnett Johnson (now McKenna) prepared a statement 10 days after the event, in which she could summon only a few

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[104] Transcript, Nov. 20, 2007, p. 196.
[105] Transcript, Nov. 20, 2007, pp. 198, 202–03, 205.
[106] Transcript, Nov. 26, 2007, pp. 13–24, 41, 56, and 65–66.
[107] Transcript, Nov. 26, 2007, p. 1.

basic facts. When she testified, she had no recollection of the event, but she did recall preparing the statement, and saying to Sgt. Sanderson that there had to be a better place for Mr. Paul than the Jail.[108]

Nurse Ruth Brandon, a long-serving Jail nurse on duty that evening, testified by video conference. She could not recall any of the events of that evening, other than confirming that she had provided a statement when asked to do so, after Mr. Paul's body was discovered.[109]

d. The audio recording of what was said

Two audio recordings assist in determining what happened in the Jail that evening.[110] Although the recordings may not have captured everything that was said within the elevator, they represent fresh and previously unexamined evidence that sheds substantial light on what happened. I caution that the poor quality of the recordings means that there is a possibility of omissions and mis-transcriptions.

The audio recording begins with someone asking, "What we got here?" Someone says, "They picked him up at Dunlevy and Hastings. State of intoxication SIPP. Turner." From the sequence this would appear to be either a member of the staff watching Paul's arrival in the bay on the Jail video, or Cst. Instant conveying information about where Mr. Paul was arrested.

There appears to be a direction from Sgt. Sanderson, for Cst. Instant not to take Frank Paul out of the elevator: "Frank, hang on a sec, Frank."

Then there are three statements, apparently by two or more people: "Is Frank Paul here? Frank, are you still here? When was the last time you had a drink, Frank?" It is not clear who says these things; it is unlikely to be Cst. Instant and may be a mixture of comments by Sgt. Sanderson and others.

[108] Exhibit 51.
[109] Transcript, Feb. 14, 2008, pp. 149–52.
[110] Exhibits 45, 188 and 192.

The audio records someone saying, "He can't walk. He sleeps anywhere he can now. He's totally incapable of walking. It took him three-quarters of an hour to get through the elevator bay." This appears to all be one voice and is difficult to attribute to Cst. Instant, as it is unlikely that he would have known about the earlier release from the wagon bay. It may be Sgt. Sanderson explaining away Mr. Paul's immobility, or perhaps a Jail staff member volunteering information about Mr. Paul.

Then someone, probably Sgt. Sanderson, asks, "Frank, have you been drinking since we kicked you out of here today?" The reply is unintelligible, but sounds like a negative response. This is at odds with Cst. Instant's recollection that Sgt. Sanderson asked Paul if he had a drink over the past three days and was told no. The audio recording confirms that whatever information the Jail staff received concerning Frank Paul's recent drinking from him was confined to a single one-word response.

Next, someone asks, "Frank, you're back?" and the answer is "yeah." This is likely a different Jail staff member speaking into the elevator.

Someone asks, "What are you doing in Kitsilano, Frank? What's the address?" to which the answer is "Broadway or Maple." This phrase was not understood by many at the time, so it may be that someone, perhaps Sgt. Sanderson, has repeated it after Mr. Paul said it.

The audio transcript confirms that Sgt. Sanderson gives the direction, "Take him and release him." Someone comments, "In the wagon for over an hour," perhaps referring to the wagon bay earlier that day—this would not be a reference to the police wagon, as Mr. Paul had only been in there a short while.

Next, Cst. Instant asks, "So you can, uh, authorize a breach?" prompting Sgt. Sanderson to reply, "Oh yeah, not a problem. That's fine. Yeah, take him to Broadway and Maple, if you don't mind."

The last recorded comment is, "You guys go and help get Frank get his butt back in the wagon before he gets too [unintelligible] in here? Okay

you guys. That's all you gotta do." This would be Sgt. Sanderson directing not only Cst. Instant, but also Greg Firlotte, to take Mr. Paul away.

The recording is useful for several reasons:

- It dispenses with the suggestion that there was any concerted or general decision to refuse Frank Paul admission to the Jail. No one other than Sgt. Sanderson is recorded as expressing any opinion on that question.
- It confirms Sgt. Sanderson's central role in the decisions made at the Jail.
- It confirms Cst. Instant's recollection that Sgt. Sanderson was outside the elevator door when he and Mr. Paul arrived in the elevator, and they were stopped before progressing into the admissions area.
- Sgt. Sanderson clearly directs that Mr. Paul be released, and repeats that direction.
- When Cst. Instant asked Sgt. Sanderson if he would authorize the use of the breach procedure (which by VPD policy was in that situation required to be authorized by him), he clearly does so.
- It confirms that Mr. Paul's release earlier that day was the subject of comment and that he was asked if he had been drinking in the short time since he was released. The recording does not record any person stating that it was impossible for him to get drunk, and the recording is consistent with the interval being remarkable for its brevity but not for the outcome of Mr. Paul being drunk once again. It is not possible from the recording to conclude that the Jail staff believed Mr. Paul to be drunk, or for that matter, sober.
- It confirms the superficiality involved in the police "assessment" of Mr. Paul at the Jail. He was asked a few questions and gave only a few short answers. The video and audio both confirm that little or no care was taken to assess what Mr. Paul's condition was that evening.

6. Events at the Cobalt Hotel

Cst. Instant testified that after he and Mr. Firlotte put Mr. Paul into the wagon, he was dispatched to the Cobalt Hotel, in the 900 block of Main Street, about seven blocks south of the Jail. As he drove, he processed Sgt. Sanderson's direction to take Mr. Paul to Broadway and Maple, and realized he needed more information.

When he arrived at the Cobalt Hotel, he met three police officers on the sidewalk—Cst. Candace Murray, Cst. James English, and Sgt. George Wood. They had three men in handcuffs. Cst. Instant decided to move Oscar Angel from the rear compartment to the side compartment, so there would be no mixing of those with handcuffs and those without. Cst. Instant testified that in placing Mr. Angel in the side compartment, he observed Mr. Paul sitting on the second step of the compartment, eyes open, looking at him. Cst. Instant told Mr. Angel to hop up inside, and told Mr. Paul, "Frank, you're going to have company," to which Mr. Paul "made a mumble." Mr. Angel crawled over Mr. Paul to the bench seat. Cst. Instant then placed the three new individuals in the rear compartment.[111]

While at the Cobalt Hotel, Cst. Instant spoke with Cst. English. According to Cst. Instant:

> I told him, I said: Look, I have Mr. Paul in the wagon. He can't go to Detox so I took him to the Jail. The Jail NCO told me that he wasn't drunk and take him to Broadway and Commercial—sorry, Broadway and Maple. And I said: Does that make sense to you? And he said: Mr. Paul's homeless, he doesn't live there.... I said: Okay. Where do you think I should take him? And then Cst. English said: You know what, the best spot is probably the lane behind Detox. That's a safe place to release him.

Cst. Instant understood this to refer to the laneway generally rather than directly at the entrance to the Detox Centre. Cst. Instant also testified that he told Cst. English that Mr. Paul was not intoxicated.[112] According to Cst. Instant, he told Cst. English: "Okay, I'll think about it."[113]

According to Cst. English, Cst. Instant was "a little bit beside himself," and said he had Mr. Paul, who was drunk, and that the sergeant told him to take him to Broadway and Maple, where he lived. Cst. English said he told Cst. Instant that Frank Paul was homeless and suggested that he try taking Mr. Paul back to the Jail, but that Cst. Instant did not want to go back to the Jail.

Cst. English said they discussed taking Mr. Paul to a hospital, but Cst. Instant said he was drunk, not injured, so the hospital wouldn't take him. Further,

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[111] Transcript, Jan. 11, 2008, pp. 5–9, 12.
[112] Transcript, Jan. 11, 2008, pp. 12–14.
[113] Transcript, Jan. 11, 2008, p. 13.

Cst. English recalled telling Cst. Instant to discuss the matter with his sergeant, Sgt. Winters, but Cst. Instant said he was not available.

Finally, Cst. English said he told Cst. Instant to talk with Car 10, an inspector with city-wide oversight of the force. He added that if the Detox Centre would not admit Mr. Paul, he had the option of driving around with him in the wagon all night, or if he were released, he might be released right at the door of Detox Centre, to "force their hand to admit him." Cst. English said Cst. Instant said he'd deal with it, and got in the wagon.[114]

Cst. English did not provide a statement about what happened that evening until nine months later. Indeed, the evidence suggests that VPD investigators found it difficult to obtain a statement from him, and had to repeatedly make efforts to get one. There are several inconsistencies between his written statement and his testimony. For instance, he made no mention in his statement of getting advice from a senior officer; driving around all night with Mr. Paul in the wagon; or trying to persuade the Detox Centre to admit Mr. Paul.

7. Events at the Vancouver Detox Centre

After leaving the Cobalt Hotel, Cst. Instant drove to the Detox Centre. He testified that he backed his wagon in to the entrance bay, and got out. He rang the buzzer and a Detox Centre worker came out and walked over to the side compartment with him, to get Mr. Angel. Cst. Instant helped Mr. Angel out and walked him over to the entrance door of the Detox. While at the side of the wagon, the Detox Centre worker (John Collens) asked, "What about Mr. Paul?" Cst. Instant replied, "No, he's not for you, he's going to be staying with me." Cst. Instant testified he did not ask to have Mr. Paul admitted at the Detox Centre because he didn't believe he was drunk.[115]

Currie Low, a nurse at the Detox Centre, testified that at about 9:00 p.m. she was working with John Collens when the police wagon came to the Detox Centre. She recalled that Oscar Angel was brought in, but Mr. Paul was not. She testified that

[114] Transcript, Nov. 29, 2007, pp. 102–09, 140.
[115] Transcript, Jan. 11, 2008, pp. 17–18.

the officer said that Mr. Paul "had been in and out of jail most of the day and that they were going to release him out of the area."[116]

According to John Collens, the police wagon came into the Detox Centre at about 9:00 p.m., and he went out to meet the officer:

> I asked him how many and he said he had one client for detox and another client in the wagon. So I went with the wheelchair[117] to assist the one client that was coming in, who was Oscar Angel, and then the officer said the other client was Frank Paul but Frank wasn't being brought to [the sobering unit at the Detox Centre] that evening, that he had been in lock-up all day.[118]

Under cross-examination, Mr. Collens qualified this statement to say that the officer had said Frank Paul was "in and out of jail that day and he wasn't intoxicated and, therefore, he didn't require the services of the sobering unit."[119] This view accorded with his written statement prepared shortly after the incident.[120]

Prior to the commencement of this commission it had been suggested that Mr. Paul may have died before he was taken out of the wagon. Mr. Collens's evidence that Mr. Paul was alive, however, satisfies me that Mr. Paul was still alive, particularly when coupled with the evidence of Patrick Lewis, which I shall address shortly. Briefly stated, all the evidence shows he was still alive in the wagon when Cst. Instant went to the Detox Centre.

Mr. Collens went to the rear of the Detox Centre building, where the laneway ends and where the police wagon had backed up. He recalled seeing Mr. Paul, whom he knew, sitting in the side compartment with Mr. Angel, and that he was hunched over and sitting in the corner. Mr. Collens said, "He looked at me when I said hello to him." He explained that while Mr. Paul did not move or make any

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116 Transcript, Nov. 26, 2007, pp. 97–100 (quotation p. 100); Exhibit 31.
117 This is a point of difference between Mr. Collens and Cst. Instant, who said Mr. Angel was walked in, not taken by wheelchair.
118 Transcript, Nov. 27, 2007, pp. 73–74.
119 Transcript, Nov. 27, 2007, p. 107.
120 Exhibit 38 (prepared December 12, 1998).

noise, he did look at him.[121] Mr. Collens said that the officer indicated Mr. Paul was being taken out of the area.[122]

It appears that approximately six months after the incident, lead investigator Det. Doug Staunton asked Mr. Collens to canvass the recollection of his co-workers, in particular as to whether they recalled some discussion, between the Detox Centre staff and Cst. Instant, about a new shelter called the Haven. The staff members he spoke to could not recall such a conversation.[123] Cst. Instant, in his statements at the time and in his testimony, recalled no discussion about a particular shelter. I find the evidence that there was mention of a shelter to be highly uncertain and I conclude that this was not spoken of in Cst. Instant's presence. In addition, I see no reason why Cst. Instant would have disregarded such information if it had been given to him in the form of a recommendation by Detox Centre staff.

The activities and conversations in the alley behind the Detox Centre are tragically pivotal—but it is the lack of conversation and clear communication between the VPD and Detox Centre staff that is most salient. Sgt. Sanderson's earlier assertion that Mr. Paul was banned from the Detox Centre, although wrong, may have reflected his own belief.[124] There was evidence that Mr. Paul had stayed overnight at the Detox Centre the previous night without incident, and Cst. Instant had not been told that Mr. Paul was banned from the Detox Centre.[125] One more question at the Detox Centre may have prevented Mr. Paul's death in the alleyway. It would appear reasonable that the Detox Centre would have taken Mr. Paul, if Cst. Instant had said something to the effect of, "I'm about to drop Mr. Paul in the alley, any chance you could take him?" Similarly, if Mr. Collens had suggested that he would take Mr. Paul, or asked to take a closer look at him, Mr. Paul may have been admitted to the Detox Centre.

It is clear from the evidence that there was no coordination between the VPD and the Detox Centre as to who would be accepted to the Detox Centre.

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[121] Transcript, Nov. 27, 2007, pp. 74–82.
[122] Transcript, Nov. 27, 2007, p. 91.
[123] Transcript, Nov. 27, 2007, pp. 84–85: Exhibit 39.
[124] The evidence on this question of how people were banned and whether Frank Paul was on any blacklists was so equivocal as to be unreliable.
[125] Transcript, Jan 11, 2008, p. 152.

8. Leaving Frank Paul in the alleyway at about 9:00 p.m.

Cst. Instant testified that, after leaving Mr. Angel at the Detox Centre, he drove down the lane trying to decide on the appropriateness of the location to leave Mr. Paul, given what Cst. English had said to him. He looked around, trying to find a location that he thought would be safe. He settled on a spot close to Scotia Street on the north side of the alley:

> And that was a large gravelled area that was well illuminated, lots of light, and there was a large shrub hedge there, and I felt that that was a good area to release Mr. Paul to while he collected himself and continued on his way.[126]

Cst. Instant gave the following account of how he handled Mr. Paul. He said that he pulled the wagon over to where the asphalt of the alley and gravel met, got out and opened the side door. He said, "Frank, it's time to get out." Mr. Paul placed his right hand on the side door and leaned back, so Cst. Instant took his legs and slid them out off the step. He then lifted him out by his arms, walked him to the wall of a building and sat him down. Mr. Paul did not say anything. His clothes were in a normal position. He stated that Mr. Paul had just one shoe on when he sat down, so Cst. Instant went back to the wagon to get the other shoe, which he put on.[127] Cst. Instant described that when he put Mr. Paul's shoe on, his leg was outstretched and the back of the shoe was broken down, so that it just slipped onto his foot.[128] This is consistent with the photographs showing Mr. Paul's shoes to be broken down at the heel. Cst. Instant left Mr. Paul in the alleyway sometime between 8:51 p.m. (when he left the Detox Centre) and 9:02 p.m. (when he arrived back at the Jail).[129]

December 5 was a cold night, about five degrees Celsius, according to Cst. Instant. It had rained off and on, and the laneway was wet. Cst. Instant recalled that where he left Mr. Paul was dry and offered shelter, close to a major street, and was in an area Mr. Paul would have been familiar with. He knew that police vehicles and the Saferide van frequented the alley. The shelter he referred to was a slight overhang of a building, and a very large shrub or hedge. However, he

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126 Transcript, Jan. 11, 2008, p. 20.
127 Transcript, Jan. 11, 2008, pp. 27–30.
128 Transcript, Jan. 11, 2008, p. 134.
129 Transcript, Jan. 11, 2008, p. 34.

agreed, after looking at photographs of the area, that the building afforded no protection from the rain.[130]

Cst. Instant did not conduct his own assessment of Mr. Paul's state of intoxication or his health and did not ask him how he was feeling.[131]

9. After Cst. Instant drove off

Patrick Lewis testified that at about 10:00 p.m. that evening, he was a passenger in a taxi travelling north on Scotia Street, as it passed the laneway where Mr. Paul's body was later found. He testified:

> The cab was coming I guess it would [be] north on Scotia downhill, and as it approached the intersection it slowed. I was sitting on the right-hand side looking out the window and as the cab passed by the alleyway I saw an individual lying in the alley. He was rising up on his elbows. My recollection is he was on two elbows but it may have just been one. He was rising up. His face was toward the cab, he was facing out of the alley.[132]

Mr. Lewis testified that the man's head was to the west (toward his taxi), and he was "basically prone on the alleyway, in the middle of the alleyway, and was rising up." No one had previously shown Mr. Lewis any photographs. When he saw a photograph of the alley, he located the place where he saw the person who must have been Frank Paul. The place he indicated was away from the building and away from where his body was found. He could not see the man's face because he had "straggly hair."[133] Mr. Lewis went on to a loud party nearby. He recalled trying to telephone about the man, but the phone was in use and he became distracted. Later on, some people from the party discovered Mr. Paul's body and called 911.[134]

Mr. Lewis's observation must be considered a fleeting glance at the alleyway, as he drove past on a dark winter night. However, he was clear (and was not challenged) about seeing a man in the alleyway who was propped up. This evidence is further confirmation that Mr. Paul was alive in the alley at about 10:00 p.m.

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130 Transcript, Jan. 11, 2008, pp. 19–24.
131 Transcript, Jan. 11, 2008, p. 35.
132 Transcript, Nov. 23, 2007, p. 2.
133 Transcript, Nov. 23, 2007, p. 3.
134 Transcript, Nov. 23, 2007, pp. 7–8.

D. The Events of December 6, 1998

1. Discovery of Frank Paul's body

David Kelly was a guest at the same party that Patrick Lewis attended, in the very building that Cst. Instant placed Mr. Paul behind. He testified that between 2:30 and 3:00 a.m., some people at the party went outside to look for the host's lost cat. A man named Colin came inside and Mr. Kelly heard him say that he had found a body; the man called 911.

Mr. Kelly, recently trained in CPR, went out to check on the person's pulse. He said the body was in the middle of the alleyway, face-up, with his head angling slightly away from the building. His pants were pulled down near his hip area and his lips were retracted a bit from his teeth. He noted a clothing tag close to his head, and a piece of eavestrough. He checked unsuccessfully for a pulse.[135] Mr. Kelly recalled that the body was more toward the middle of the laneway than the photographs of the scene depict, but equally he volunteered that it was 10 years ago and it was dark outside.[136]

When I examine the police photographs of the body's location, I can see what looks to be the clothing tag and the piece of eavestrough near Mr. Paul. Given the other evidence, which I will discuss momentarily, I believe Mr. Kelly is correct to be skeptical about his recollection of exactly where the body was in the laneway.

Colin Robertson did not testify, but I accepted into evidence his 911 call, and a transcript of his police interview, which were part of the VPD's Sudden-Death Report.[137] According to Mr. Robertson, he was at the house party and went out looking for the lost cat at about 2:30 a.m. He came across Mr. Paul just off the pavement, lying on his back. His pants were pulled down somewhat and he had no shoes on, although his shoes were nearby. He called 911 and returned to the scene, where he met with the police.

2. Attendance of police officers at the scene

Cst. Darryl Ell was a police wagon driver. At approximately 2:30 a.m., as he pulled into the alleyway on his way to the Detox Centre, two white males flagged

[135] Transcript, Nov. 30, 2007, pp. 61, 65–73.
[136] Transcript, Nov. 30, 2007, pp. 76–78.
[137] Exhibit 91, pp. 62–75.

him down, and said there was a man who was not breathing. Cst. Ell got out and walked over to the male. He saw Frank Paul on his back, lying in a grassy area just to the side of the alleyway, immediately to the north of the gravel. His pants were down past his groin area and he was not wearing shoes. Within a few moments of Cst. Ell speaking to these males, Sgt. Ray Winters pulled into the laneway, followed by the ambulance. Cst. Ell then carried on toward the Detox Centre.[138]

Both Csts. Turner and Peterson, who had arrived on the scene, testified to a memory of Mr. Paul being seated against a building, slumped forward, when they attended the laneway. Cst. Turner prefaced his testimony by saying, "my memory is a little fuzzy on this."[139] He later added, "It's [an] image I seem to have, but I can't be a hundred percent sure I'm thinking of the right incident."[140]

Cst. Peterson said:

> ... upon arrival, my memory of the discovering of Mr. Paul was driving unto the rear of the location, seeing Mr. Paul against the rear of this building in a slouched but seated position and I have a faint memory of light rain at that time.[141]

Cst. Peterson also testified that he spoke with an eyewitness who had come across Mr. Paul's body before he did, who described a "male laying next to the lane."[142]

There was conflicting evidence from police witnesses about which officers arrived in the laneway first. Csts. Turner and Peterson, working together, both said they were the first unit there.[143] Acting Sgt. Winters, meanwhile, was not sure who was there when he arrived, but he remembered that Csts. Turner and Peterson came after he did.[144] Cst. Ell was clear in saying that he was there just moments before Sgt. Winters, and that Csts. Turner and Peterson arrived afterward. Nothing of significance turns on this point, but I find it unlikely that Csts. Turner and Peterson were the first to arrive.

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138 Transcript, Nov. 29, 2007, pp. 77–85.
139 Transcript, Nov. 26, 2007, p. 172.
140 Transcript, Nov. 26, 2007, p. 174.
141 Transcript, Nov. 27, 2007, p. 145.
142 Transcript, Nov. 27, 2007, p. 164; Exhibit 41.
143 Transcript, Nov. 26, 2007, p. 174 (R. Turner); and Transcript, Nov. 27, 2007, p. 145 (Cst. Peterson).
144 Transcript, Nov. 29, 2007, pp. 6, 16.

There is conflicting evidence about the location of Mr. Paul's body. Cst. Instant testified that he placed Mr. Paul against a building, and Csts. Turner's and Peterson's best recollections were that Mr. Paul was propped up against a building when they arrived on the scene. Neither constable included mention of this very important fact in his statement prepared at the time, which causes me to approach their recollection with caution, as new evidence emerging nine years later in very similar terms from two patrol-mates. Their evidence does not accord with any other evidence respecting where Mr. Paul's body was found, including that of Sgt. Winters.[145]

If the civilian witness, Colin Robertson, had described this—and there is every reason to believe he did, as it accords with his 911 call and his statements to police—it would be startling and unusual for the officer to find that the body was in an entirely different place. It would mean either (1) someone had moved the body before the police came; or (2) the witness he was dealing with was blatantly lying. Both propositions would be amazing. I cannot accept that this would have passed without notice.

Was the recollection of Csts. Turner and Peterson influenced by what Cst. Instant said?[146] This may be a case of fading memories, coloured by a memory of what was said about Mr. Paul's position, rather than what was observed. In light of the evidence from civilians as to Mr. Paul's position in the laneway, some distance away from the wall, on his back, I do not accept the recollections of Csts. Turner and Peterson on this point.

3. Attendance of ambulance attendants at the scene

Two ambulances attended the alleyway near the Detox Centre. Marilyn Oberg and Ward Findlay were in an Advanced Life Support (ALS) vehicle which carries sophisticated life-support equipment. Ms. Oberg knew Mr. Paul and noted that he had recently had a haircut. They checked his vital signs and used a defibrillator to check for electrical activity in his heart. He showed lividity and rigor, indicating he was dead. They phoned a doctor at Vancouver General

[145] Transcript, Nov. 29, 2007, pp. 3, 11. Further, there is Cst. Peterson's recollection that one eyewitness described a male lying next to the lane.
[146] Indeed, Cst. Peterson has, since this incident, spoken with Cst. Instant and recalls Cst. Instant "saying that he had put [Mr. Paul] against the wall in the lane at detox [Centre]"; this may be the source of the "memory" of this fact. Transcript, Nov. 27, 2007, p. 148.

Hospital for orders, and were told to discontinue their efforts to resuscitate Mr. Paul.[147] Ms. Oberg testified that the photographs showing Mr. Paul's body accurately showed where he was when the ambulance attendants found him.[148]

Fernando Grossling, an attendant in the other ambulance, recalled the call being a "code 4," meaning an obvious death. He remembered gravel having been moved in the area of the body, like a snow angel, which he speculated may have been from a seizure.[149]

Cst. Instant testified that he attended the scene after learning of the sudden death though the police dispatch system. He was shocked. He told Sgt. Winters that he had put Mr. Paul there. He asked Sgt. Winters if he could take a look at Mr. Paul, and Sgt. Winters permitted him to do so. Cst. Instant then testified: "I walked back to Sgt. Winters and I asked Sgt. Winters if he had been moved, did EHS move him."[150]

The fact that Cst. Instant asked this question suggests that he was puzzled as to how Frank Paul made it away, on his own, from the building wall where Cst. Instant had left him several hours earlier. It confirms, at the least, that Cst. Instant was skeptical that Frank Paul was capable of any significant movement after he left him in the alley.

E. Discussion of Factual Issues

1. Events at the Jail

a. Validity of Frank Paul's 8:00 p.m. arrest

I am left with no doubt, on the evidence, that by any measure Frank Paul was not capable of caring for himself when he was arrested, at approximately 8:00 p.m., for being in a state of intoxication in a public place. The evidence of the arresting officers, the videotape evidence and

[147] Transcript, Nov. 22, 2007, pp. 14–16.
[148] Transcript, Nov. 22, 2007, p. 24; see also evidence of W. Findlay, Transcript, Nov. 23, 2007.
[149] Transcript, Nov. 23, 2007, pp. 44–46. There was evidence, from Ms. Oberg, of Mr. Paul having a history of seizure activity.
[150] Transcript, Jan. 11, 2008, pp. 35–37 (quotation p. 37). Cst. Instant wrote out a brief report describing his dealings with Mr. Paul. His handwritten report gives a time of 3:53 a.m., and this would appear to be accurate. Cst. Instant then prepared a three-page typewritten duty report with his lawyer, which was dated December 7, one day after the incident in question. Both statements are contained in Exhibit 74.

the eyewitness accounts all lead to only one conclusion—that Mr. Paul was intoxicated and was, for that reason, clearly unable to care for himself.

I appreciate that there is a basis for suggesting Mr. Paul had Wernicke-Korsakoff Syndrome, but the evidence in this case supports the further conclusion that he was in fact intoxicated by alcohol that night.

He was virtually unresponsive, limp in the arms of the officers, and uncommunicative to the point of stating only a word or two. He smelled of rice wine and I am satisfied, for the reasons I explore below, that there were many ways he could have obtained that drink in the few hours since his release from the Jail that afternoon. Indeed, he may have used the two-dollar coin that Cst. Prince kindly gave him to purchase some or all of a bottle of rice wine, which he then consumed.

There was ample evidence that Frank Paul was severely intoxicated, and required shelter in the Jail's sobering cell or at the sobering unit of the Detox Centre.

b. Jail staff involvement in assessing whether Mr. Paul was capable of caring for himself

While it is fair to say that staff members expressed surprise that Mr. Paul had become intoxicated so soon after having been released at 5:00 p.m., I am not satisfied that members of the Jail staff, other than Sgt. Sanderson, participated in the decision that Mr. Paul was capable of caring for himself. The elevator was at the Jail floor for only a few minutes and, during that time, Mr. Paul remained inside the elevator. Although several people apparently looked into the elevator, there is no suggestion that anyone other than Sgt. Sanderson attempted an assessment of Frank Paul's condition.

c. Did Sgt. Sanderson believe that Frank Paul was capable of caring for himself?

The more difficult question is what was truly in the mind of Sgt. Sanderson. We have no contemporary record, pre-dating the discovery of Frank Paul's body, that directly informs us what Sgt.

Sanderson believed. The videotape does not capture the interaction within the elevator, and the audiotape is equivocal on this point.

There are many problems with Sgt. Sanderson's evidence, and I find it in virtually every respect unsatisfactory. In some respects it was implausible, and clearly was contradicted by other evidence. For example, I have difficulty with his response to being asked to compare the state of Mr. Paul's intoxication when leaving the Jail earlier in the day, with his later state when he was returned to the Jail by Csts. Peterson and Turner. Sgt. Sanderson was asked to rate Mr. Paul's level of intoxication, as seen on three different video clips. He rated the images showing Mr. Paul crawling into the Jail that morning as "most drunk," but the images of Mr. Paul departing the Jail at 5:30–6:30 p.m. and his return at 8:30 p.m. (being dragged by Cst. Instant) both tied for "least drunk."[151] It is difficult to accept that he was more drunk at a time when he was able to crawl on his own, drink a cup of coffee and eat a bag of chips, than when he had to be dragged into the police station.

This evidence was, in my view, the product of Sgt. Sanderson's determination to hold to his story, rather than an honest review of the videotapes and a meaningful reflection on the events of that night. Indeed, Sgt. Sanderson was so determined that he suggested that the toxicology finding, proving that Frank Paul's blood-alcohol level was very elevated before he died, could have been the result of Mr. Paul leaving the laneway, getting alcohol, and then for no reason returning to the same exposed laneway after becoming intoxicated.[152] This absurd suggestion demonstrates starkly what I would have to accept in order to support Sgt. Sanderson's assessment at the Jail, that Frank Paul was not intoxicated.

Sgt. Sanderson testified that his decision not to admit Mr. Paul was motivated by concerns for the legality of holding him and for ensuring he

[151] Transcript, Jan. 9, 2008, pp. 79–80.
[152] Transcript Jan. 8, 2008, p. 144; and Jan. 9, 2008, pp. 23–26. Moreover, it is logically inconsistent to suggest, as Sgt. Sanderson seemed to, (1) that Mr. Paul could not have obtained alcohol at about 6:00 p.m. in the Downtown Eastside, but (2) that he *could* have found alcohol in a laneway a dozen blocks away, a few hours later.

did not breach his rights under the *Canadian Charter of Rights and Freedoms*. Given his conclusion that Mr. Paul was not drunk, there was in his mind no lawful basis to keep him in custody at the Jail. He testified:

> ... I believe that he had been arrested in error and the arrest was unlawful which meant that there [was] no power to detain Mr. Paul and that he should be released immediately as it was contrary to his rights and freedoms.[153]

Despite this apparent interest in ensuring the legality of Mr. Paul's detention, Sgt. Sanderson went on to authorize a breach of the peace under the *Criminal Code*, which he accepted was a tool of convenience rather than a proper legal basis for keeping Mr. Paul in custody and relocating him within the city. In response to questions from lawyer Steven Kelliher, he stated:

Q He's being released on a breach?

A He's being released.

Q Pursuant to a breach?

A Well, it was not my idea that it was going to be a breach. He was just being taken home as far as I was concerned.

Q But isn't that what Officer Instant said to you, "Look, am I going to treat this as a breach?"

A Technically that's what he said, yes.

Q And you said yes?

A I did not consider it a breach in my own mind, though.[154]

Furthermore, rather than releasing Mr. Paul "immediately" in the absence of any lawful authority to hold him, as Sgt. Sanderson described, he instead authorized Mr. Paul to be held in custody for a further period while he was "breached" elsewhere. The logic requiring immediate release

[153] Transcript, Jan. 7, 2008, pp. 34–39 (quotation p. 39).
[154] Transcript, Jan. 8, 2008, pp. 128–37 (quotation pp. 128-29).

was apparently forgotten with the direction that Cst. Instant keep Mr. Paul in the wagon and release him elsewhere.

Sgt. Sanderson testified that there were two questions in a H/SIPP scenario. First, was the person intoxicated and creating a disturbance? Second, was the person so intoxicated by drug or alcohol that he was unable to care for himself?[155] The focus in Mr. Paul's case had to be on the second part of the test. I pause to consider this "test." It focuses on whether the person can "care for himself."

VPD policy required consideration of a person's state of intoxication for the purpose of determining whether the person can care for himself.[156] Indeed, if a person was found so intoxicated as to be unable to care for himself, but was a businessman or a teenager overtaken by excessive consumption of alcohol, they could be released into the custody of a friend or family member who was prepared to undertake to warrant their safety.

Although Sgt. Sanderson said he could not believe Mr. Paul could be drunk approximately two hours after his release, he did concede that a chronic alcoholic, given access to alcohol upon release from jail, could be expected to drink it in a short period. Sgt. Sanderson's disbelief in Mr. Paul being intoxicated appeared to stem from his view that, logistically, a person in Mr. Paul's physical condition could not obtain alcohol that quickly at that time on a Saturday night. The following evidence does not support the view that it was impossible for Mr. Paul to get drunk in a two-hour period after leaving the Jail area.

- Witness Barry Conroy worked for Saferide and at the Lookout Shelter in the Downtown Eastside in 1998. He knew Frank Paul, through many dealings on an almost daily basis. He testified that a person could get drunk very quickly in the area of the police station, even without money: the person could panhandle, or run into another group of people who had alcohol, or might have enough money in their pocket to get to a corner store to buy

[155] Transcript, Jan. 7, 2008, p. 41.
[156] Transcript, Jan. 7, 2008, p. 41.

alcohol.[157] At the time, rice wine was available in corner stores in the Downtown Eastside for approximately two dollars a bottle.

- Cst. Turner testified that in late 1998, rice wine was readily available in most of the stores in Chinatown, and corner markets were selling it as well. Cst. Turner said, in the area where Mr. Paul was found, "I'm certain that there would have been corner stores" that sold rice wine. He also stated that Mr. Paul's breath smelled of rice wine, a readily discernible odour.[158]
- Retired Insp. Kenneth Frail testified that there were 17 convenience/corner stores in the Downtown Eastside selling rice wine in the mid to late 1990s: "It was real cheap and it was available on the Downtown Eastside." The cost was as low as $1.25 a bottle to a high of $7.00 on "Welfare Wednesdays." He said: "I know that it was quite easy to get access to it at just about any hour." He added that, in the area of the Jail, one would not have to go far to find such a store, perhaps not more than a block.[159]

With the benefit of the post-mortem report and a toxicology analysis placing Mr. Paul's blood-alcohol level at a very high level, the only reasonable conclusion is that Mr. Paul was indeed intoxicated when Cst. Instant brought him into the Jail. Sgt. Sanderson refuses to acknowledge, even today, that he may have erred in his assessment.

Sgt. Sanderson's "assessment" of Mr. Paul was quick and cursory, taking approximately four minutes. It was founded in part by his hearing four words: "no," and "Broadway and Maple."[160] The "no" may have sounded more like a grunt. He did concede that Mr. Paul smelled of rice wine.

Sgt. Sanderson's evidence, to the effect that Mr. Paul was in the same condition as when released earlier, is not tenable. When Mr. Paul left the Jail after 6:00 p.m., he was able to walk off the elevator, sit down, dress himself (albeit awkwardly), eat food, drink coffee, rise to his feet and walk away. He left of his own volition and "under his own steam." When Cst. Instant brought him back to the Jail that night, he was immobile and had to be dragged. Nothing indicated that he could move on his own initiative, or that he had the motor skills to eat food or dress himself.

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[157] Transcript, Nov. 16, 2007, p. 55.
[158] Transcript, Nov. 26, 2007, pp. 148–50.
[159] Transcript, Jan. 29, 2008, pp. 124–26, 164–67, 175–76.
[160] Transcript, Jan. 8, 2008, p. 93.

Ultimately, two good-sized men had to drag Mr. Paul out of the Jail and back into the wagon.[161]

I contrast Sgt. Sanderson's cursory assessment of Mr. Paul with what ambulance attendant James Douglas described as his usual practice. In response to questions during our hearings, he stated:

> A Our initial approach would be to try to gain the person's attention verbally by introducing ourselves, asking are you all right? If that didn't work, the next procedure would be then to actually put hands on the person, give them a shake, perhaps use a pain stimuli to elicit a response.
>
> Q What do you mean first with a shake, what would you do for that?
>
> A I might put my hands on their shoulder and give them a gentle shake and also a verbal hello, can you hear me, can you hear me, and see if there's a response from that.
>
> Q When you say pain stimulus, what sort of steps would you take there?
>
> A The classic method of a pain response on a person in this condition would be to squeeze the trapezius muscle at the base of the neck hard enough to instill some pain is a classic method.[162]

Mr. Douglas stated that he would then move into a patient assessment model, the elements of which would depend on whether the person was considered unconscious or not. Particular attention would be given to signs of intoxication, such as:

> Slurred speech, involuntary eye movement, uncoordinated motor function, obvious smells of alcohol, odour of alcohol in the immediate vicinity, right down to any physical evidence of alcohol on the person or in the immediate area.[163]

One of Sgt. Sanderson's major failings was not taking any steps to properly assess Mr. Paul's actual state—in particular, his medical

[161] Transcript, Jan. 8, 2008, pp. 85–91.
[162] Transcript, Nov. 16, 2007, p. 76.
[163] Transcript, Nov. 16, 2007, p. 78.

condition. It would not have taken much. A nurse or medical practitioner could have examined Mr. Paul to determine his condition.

The Jail sergeant bore the responsibility for ensuring Mr. Paul's safety. He was the sergeant in charge and this man was under his control. His approach to the situation was inadequate and set in motion the events leading directly to Mr. Paul's death.

Sgt. Sanderson's only regret or ambivalence related to his instructions to Cst. Instant. He remained steadfast that Mr. Paul was not drunk when Cst. Instant brought him in. Whatever his views at that time, I would have expected that after having the benefit of the toxicology analysis, the post-mortem report and the facts as they have since emerged, he might now acknowledge some possibility that he got it wrong.[164]

Sgt. Sanderson testified that when Cst. Instant arrived with Frank Paul, he believed Mr. Paul was capable of caring for himself. It seems to me that there are three views that may be taken of this assertion:

- he was lying, and did not actually believe this;
- he was indifferent, and did not take appropriate steps to answer the question; and
- he did, in fact, believe Mr. Paul was sober and capable of caring for himself.

I have concluded that the evidence establishes the second proposition, but does not go so far as to prove that Sgt. Sanderson was lying. I wish to set out the basis for this conclusion.

There is nothing in the evidence before me—whether in the accounts of witnesses, the Jail video, or the audio recordings—that establishes any motive for rejecting Mr. Paul at the Jail. Mr. Paul was not violent or abusive; the evidence does not suggest he was refused because of disruptive or combative behaviour. Nobody expressed a positive refusal to admit him to the Jail because he had quickly become intoxicated again,

[164] As noted previously, this led him to imply that Mr. Paul could have consumed alcohol after his release by Cst. Instant in the Detox Centre laneway: Transcript, Jan. 8, 2008, p. 144; Transcript, Jan. 9, 2008, pp. 23–26.

and nobody said that the Jail should not be a hotel or should refuse a second admission in the same day. It is true, as Sgt. Sanderson's counsel points out, that Mr. Paul was disabled both physically and mentally, even when sober. In support of this is the evidence of forensic pathologist Dr. John Butt, which I review in Part 4 in discussing the pathology evidence in this case. Dr. Butt concluded that Mr. Paul may well have had Wernicke-Korsakoff Syndrome, which would result in obvious physical and mental impairments that would be present regardless of whether he had consumed alcohol. As it happens, Sgt. Sanderson's conclusion to this effect—although medically untutored—may have been accurate. That is, Mr. Paul was a man who, even when sober, would have difficulty communicating, and difficulty with his gait, balance, and mobility. He would, and did, have good upper-body strength, as attested to by some of those responding to "man down" calls.

Having said this, the inescapable conclusion from the evidence is that Mr. Paul was *not* exhibiting his "usual post-jail" symptoms, when Sgt. Sanderson refused to admit him at the Jail. While the evidence of Dr. Butt suggests that Mr. Paul may have appeared intoxicated, even when sober, it does not go so far as to suggest Mr. Paul would be immobilized and virtually nonresponsive as a result. To the contrary, I have already outlined just how big a difference there was between Mr. Paul's condition upon leaving the Jail in the late afternoon, and when he was dragged back in, soaking wet, in the evening. In these circumstances, I have concluded that Sgt. Sanderson was indifferent as to Mr. Paul's true state. On the whole of the evidence, I conclude he did not direct his mind in any meaningful way to assessing Mr. Paul's physical condition.

The general circumstances support an inference that Jail staff members were tired of caring for Mr. Paul, and that their cursory attention to him that night may have been influenced by the fact he was a chronic alcoholic and homeless.

I conclude that Sgt. Sanderson exhibited callous indifference in the exercise of his duties by failing to properly assess Frank Paul before

refusing him entry into the Jail when, by any objective measure, Mr. Paul was grossly intoxicated and incapable of caring for himself.

2. Cst. Instant's actions after leaving the Jail

One might view Cst. Instant's explanation of what he did and how he did it with skepticism. In the photographs, Frank Paul's pants are down below his waist with his torso showing, and his shoes are off. The position of the body and the condition of the clothing are consistent with someone dragging Mr. Paul and leaving him where his body was found.

Notwithstanding the appearances shown by the photographs, I found Cst. Instant sincere and convincing. He made admissions that were personally detrimental, which suggests that he was not simply trying to portray events in a favourable light. If anything, he avoided obvious opportunities to blame others for his actions. For example, the audiotape of the Jail conversation suggests clearly that it was Sgt. Sanderson who authorized a breach, but Cst. Instant took responsibility for that decision. Similarly, he accepted responsibility for deciding to leave Mr. Paul in this alleyway, despite clear evidence that it was Cst. English who first suggested it after Cst. Instant asked him for advice.[165]

It is fair to observe that some of Cst. Instant's testimony was self-serving, such as his comment to the effect that he had sought "shelter" for Mr. Paul from a building overhang, when there was no such protection. However, he was forthright in describing how he handled Mr. Paul. He admitted that his actions were inadequate and were the product of bad judgement. I accept that the circumstances of homeless chronic alcoholics were new and alien to him, and that life in the Downtown Eastside in many ways challenged what he understood until then about acceptable standards of living.

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[165] Where Cst. English's evidence departs from that of Cst. Instant, I prefer Cst. Instant's. Cst. English's evidence that they discussed seeking the advice of a sergeant (when one was smoking a few feet away and unoccupied at the time of their conversation), or seeking the advice of an inspector in Car 10, is without any credence or support in the circumstances or other evidence. I infer that Cst. English would prefer that he had not participated in that brief and fateful conversation, and in his mind believes they must have discussed alternatives. Unfortunately, I find that Cst. English's involvement worsened rather than improved the situation that Cst. Instant found himself in. Indeed, although the laneway behind the Detox Centre might be expected to have ambulance and other police traffic passing through later in the evening (which did not happen), it would have been preferable in many ways for Cst. Instant to have carried on to Broadway and Maple, since any release in that area of the city was far more likely to result in Frank Paul's condition being noticed by someone else.

I accept that he testified honestly, and I find that events occurred within the alley as he testified.

Cst. Instant was placed in a difficult position that evening. As a junior officer still under probation, he was eager to satisfy his superiors and the regular and experienced officers serving with him that evening. It would have been exceptional to question Sgt. Sanderson's direction, or seek to revisit it with another sergeant.[166] Yet he bore the ultimate responsibility for ensuring Mr. Paul's safety, and if this required him to question or even disobey an improper order, that was the course he should have taken.

I will not minimize the seriousness of Cst. Instant's conduct that night. He may have felt he was carrying out Sgt. Sanderson's direction to return Mr. Paul to the streets, and that he'd be fine there. But his conduct suggests that he knew Mr. Paul would *not* be fine. The fact that Cst. Instant sought out advice from Cst. English shows that he was concerned about Sgt. Sanderson's directions. He had other options. He could have spoken with Sgt. Wood, or called back to Sgt. Sanderson, or called for Car 10. He could have created a pretext that Mr. Paul's condition had worsened, if he needed to justify a departure from Sgt. Sanderson's direction. He could have asked Cst. English, or other officers at the Cobalt Hotel, to look at Frank Paul. He could have sought the name of an overnight shelter that would have accepted Mr. Paul. He could have asked the Detox Centre to accept Mr. Paul, or he could at least have asked the Centre's on-duty nurse to examine him. After leaving Mr. Paul in the alleyway, he could have returned later to check on him. Any of these steps may have prevented Frank Paul's death that night.

It was Cst. Instant's deference to an organizational model that discouraged questioning a superior officer that was Frank Paul's undoing that evening, coupled with the fact that Cst. Instant's training had not equipped him to seek an appropriate answer when confronted with an order that made no sense to him. The fact that someone with such an excellent training record (and such an excellent service record since that event) could have made this decision rebounds against the VPD's training in relation to ethics generally, and specifically with regard to understanding the medical and other realities of the homeless chronic

[166] See, to this effect, the testimony of B. Porter, Transcript, Jan. 14, 2008, pp. 34–35.

alcoholic population who occupied a good deal of police officers' professional attention in the Downtown Eastside.

In such a situation, it was not surprising that Cst. Instant relied heavily on the advice and directions that his superiors gave. Yet, he had a professional and moral duty to Mr. Paul, to provide for his safety, and he failed to fulfil that duty.

F. Preventing Recurrences of this Type of Tragedy

The Paul family and representatives of the First Nations Leadership Council urge me to make recommendations that will prevent a recurrence of the conduct that contributed to Frank Paul's death. In particular, they urge me to accept the evidence and recommendations of Dr. Shabehram Lohrasbe as to the circumstances under which otherwise professional and diligent officers can be led by their training and circumstances to make decisions and carry out actions that are wrong and appear inexplicable. His report and testimony were received on the basis that I would not employ this evidence to make findings of fact as to what occurred, and it was in fact too general to support such an exercise.

Nevertheless, Dr. Lohrasbe's evidence was both appropriate and useful to my work, as it offers an insight both as to how circumstances can influence the decision-making abilities of people generally, as well as to the necessity of organizations adopting positive training to overcome the natural tendency of paramilitary organizations to cultivate obedience even in the face of unacceptable risk to human safety.

The VPD received Dr. Lohrasbe's opinion and evidence favourably and, in its closing submissions, indicated that his report would be forwarded to the department's training division for inclusion within the training module already in use dedicated to ethical behaviour.

Dr. Lohrasbe Summary

I have not purported to set out a comprehensive description of Dr. Lohrasbe's testimony and report.[167] Dr. Lohrasbe is an eminent forensic psychiatrist, who provided insights into the process that can lead people in a pressured situation to do harm, although they do not intend to do harm. One must look beyond the question of (1) an individual's

[167] Transcript, Apr. 4, 2008, Exhibit 169.

disposition, and examine (2) the larger situation, and especially (3) the systems that may govern the individual's response. Western thinking typically focuses on the first level—the individual's disposition and his or her individual conduct—without stepping back to examine the larger systems which often dictate what the individual does. While many of us cling to the notion of a "fixed self" with an unchanging moral compass, Dr. Lohrasbe testified, in reality this "self" is easily altered, and responds differently depending on the situation and the systems at play. In particular, unusual, novel and stressful situations may cause a person to respond very differently than his or her individual disposition would suggest. According to Dr. Lohrasbe, "We are all much more vulnerable to group pressure than we think we are."[168]

In his report, Dr. Lohrasbe elaborated:

> However, much clinical experience and experimental research tells us that the self is un-fixed, and notions of good and bad people who act consistently in good and bad ways is a comfortable but misleading, and lazy, reading of reality. Although people think of themselves as having a steadfast personality across time and space, that perspective is not borne out of clinical or research findings. We know that how people behave depends on their situation. People and situations are usually in a state of dynamic interaction, and character can be transformed when the "self" is immersed into powerful situational forces. Situational power is most salient in novel settings, where people often cannot call on established habits of prior guidelines to deal with unanticipated choices. In such situations, dispositional variables often have little predictive value in anticipating how the individual will behave, because such predictions depend on the person's characteristic past reactions in familiar situations, not in the new or stressful situation that is currently at hand.[169]

Added to this are the tendency to defer to authority, and the newcomer's deference to a group's established routines and responses. As a consequence, it is exceptional for a person to stand up. Doing so requires effort and an emotional investment—it is easier to go with the flow. This is true both as a matter of effort, but also because people naturally want to fit in and blend in, and so they will be slow to take a position that marks them as an outsider to the group. The individual may find that "authority pressure" and group conformity are important situational influences on his or her conduct—especially where the person is under pressure to act (as opposed to simply having to agree or disagree).[170]

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[168] Transcript, Apr. 4, 2008, pp. 6–10 (quotation pp. 9–10).
[169] Exhibit 169, p. 2.
[170] Exhibit 169, p. 3.

Dr. Lohrasbe expanded on these dynamics, and how they come into force, in his report:

> Research helps us understand why people gravitate toward group conformity and hence toward unthinking acceptance of the needs of the system. We join in first because of *informational* needs: we have long learned that people more familiar with the system that is in place have the knowledge and skills that help us better steer ourselves toward safety, especially in novel or difficult situations. Secondly we have *normative* needs, the need to belong and to be seen as normal, since other people are more likely to accept us when we "go with the flow." It takes effort and energy, and courage, especially in difficult situations, to disagree, so we often yield to the general view, both by a powerful need to belong as well as a need to conserve our energy for what is specifically important to us. There are exceptions, those who provide moral leadership at critical moments of choice; such inspiration usually comes out of clear-headed observation of what is happening to the "other," rather than a preoccupation with one's own wellbeing. Hence we need to train people to put human dignity, not their own comfort, as the centrepiece of their ethical worldview. (In psychotherapy, this is a central theme in helping individuals regain self-esteem. You can "win" in a conflicted situation by taking the easy, safe, and selfish way out, but you will pay a price, in self-regard; and the costs are cumulative.)[171]

Dr. Lohrasbe offered a number of suggestions as to how people can guard against these types of problems:

- One must be mindful of the likelihood of withdrawing from forming a human connection with another person, and the risk of dehumanizing that person. This is especially true in a group dynamic where there are time pressures and where there may be a "groupthink" mentality:[172]

  > When members of a group are in an acutely deindividuated state under the pressure of unusual or threatening circumstances, individual mental functioning is altered dramatically. There is often a distortion of sense of time, and the individual functions temporarily in an *expanded-present moment* that makes past and future distant and irrelevant. In such a state, the usual cognitive, emotional, and motivational characteristics of the individual that would typically direct action are no longer available. When there is an acute and temporary disconnect from past and future, there is a separation from the lessons of personal experiences that have shaped choices and morals, as well as from normal awareness of personal responsibility and practical consequences. Another aspect of time awareness can be a situational factor, adding to demands from the group. *Time pressure* has been identified in research as a factor that has

[171] Exhibit 169, p. 6, (emphasis in original).
[172] Transcript, Apr. 4, 2008, pp. 28–31.

> accounted for loss of "moral compass" among those who could have helped a person in distress, but did not. When people are hurried and preoccupied, they tend to be less receptive to the human qualities during an interaction.[173]

- Training should encourage people to be alert to the possibility they may *not* react in a constant, predictable and ethical way, to a difficult situation. They should be vigilant to their own personal biases and should account for the sorts of pressures (lack of time, a crisis situation, working an overnight shift) that will affect their response.[174] They should be encouraged to retain a separate and robust identity, and to guard against prejudice and groupthink, which lead toward seeing others in a stereotyped and dehumanized way.[175] According to Dr. Lohrasbe:

  > Dehumanizing is not always "active" or assertive. Indifference can be just as potent. Turning away and not responding to the human needs of another person automatically facilitates inhuman actions. Indifference is a shutting down of feelings of compassion and connection for another human being, unresponsiveness in the face of someone in distress. Indifference then activates self-justification in the form of cognitive distortions ... and perpetuates itself....[176]
  >
  > Most of us believe that we know ourselves and can predict how we would respond to difficult situations. Most of us take comfort in the notion that we are different, special, and somehow less open to pressures and influences than the next person. Most of us are wrong. Our ignorance and complacency arises most fundamentally from the fact that virtually all our self-knowledge comes from reflecting on our behaviour in familiar situations, not from being exposed to totally new settings or unique situations where comfort zones are challenged and habitual responses are put to the test. If you were thrust suddenly into an extraordinary or cruel situation within a powerful system, you would probably not behave as your "familiar" self....[177]
  >
  > While obeying just authority is an essential aspect of participating in any society or system, taking personal responsibility for your *actions* with *this* human being, rather then mindlessly deferring to authority or situational pressures, needs to be promoted from the most fundamental levels of training in any system that wishes to promote a focus on human beings as its centrepiece ("The person giving *you* the order about what you should do with *this* person may be misinformed, unaware of the entire situation,

[173] Exhibit 169, p. 7.
[174] Transcript, Apr. 4, 2008, at pp. 38, 47.
[175] Exhibit 169, p. 13.
[176] Exhibit 169, p. 8.
[177] Exhibit 169, p. 10.

> or wrong. Have you given enough thought to a situation that is making you uncomfortable? Have you really considered all your options?") Encouraged to take personal responsibility and be willing to be held accountable to his actions, the person would likely become more resistant to undesirable situational pressures and system expectations....[178]
>
> Persons within systems can be trained to be alert to the earliest signs of personal compromise. They can be made to understand that when one takes the first step in cooperating with a system at the expense of one's conscience and beliefs, one risks being quickly catapulted down the path towards full compliance with group pressure or the wishes of the system. Critical thinking can be encouraged, a mindset that will resist the pull of stereotypes and simple-minded solutions.[179]

- Rather than being defensive about mistakes, as often happens in a culture where mistakes are penalized, the person should acknowledge that mistakes will occur and should own up to errors quickly, in a system that will support the individual who does so.[180] By attending to the dignity of individual human beings, Dr. Lohrasbe testified:

  > you are attending to *your* dignity. You will leave this planet with your head held up high. When you diminish other people, you are diminishing yourself.[181]

  In his report, Dr. Lohrasbe wrote:

  > If persons encountering difficult situations can be continually altered to the ethical necessity of keeping the individual human being and a dignity of all human beings as the primary lens through which they should view their choices, a strong counterbalance to situational accommodation can be encouraged.[182]

In the concluding summary of his report, Dr. Lohrasbe states:

> Individuals working in systems can be overwhelmed by situational pressures that sometimes undermine their ability to remain humane. Attention to the roles of person, situation, and system in preventing dehumanization requires a sustained emphasis, starting at the earliest stages of training, to individualize rather than diffuse the role of ethics and choice, minimize prejudice and discrimination, and keep individual human beings as the primary focus of their work. Self monitoring

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178 Exhibit 169, p. 13.
179 Exhibit 169, p. 15.
180 Transcript, Apr. 4, 2008, p. 45.
181 Transcript, Apr. 4, 2008, p. 46 (emphasis added).
182 Exhibit 169, pp. 12–13.

> can be encouraged as a habit, and anyone given authority over other human beings who may be "different" in appearance, lifestyle, and values, needs to be continuously alerted to the power of situations to distort their humanity, and to be especially vigilant at times of crises or at other times known to be associated with greater risk, such as when on the night shift, or when fatigued. Dehumanizing other human beings in difficult situations can be resisted by developing a training culture that encourages the person to be a critical thinker rather than a mindless follower, to retain a separate identity, to maintain one's own values, and hence a sense of personal responsibility for one's actions, and to quickly acknowledge one's mistakes.[183]

G. Conclusions

Sgt. Sanderson wrongly refused Frank Paul access to the Jail's sobering cell, and Cst. Instant wrongly left him exposed to the elements, when he was incapable of caring for himself and where there was obvious risk to his health and safety.

Sgt. Sanderson's explanations for refusing Frank Paul admission to the Jail are wholly unpersuasive and I reject them in their entirety. The arresting officers were correct to conclude that Mr. Paul was severely intoxicated and unable to care for himself, and they were acting within existing departmental policy in referring him to the sobering cell of the Jail.

Frank Paul's condition at the Jail without question justified his admission to the sobering cell, and also justified an immediate assessment as to whether he also required medical assistance. He made no resistance and offered no objection to people caring for him, and he did not in any way cause or contribute to being left exposed to the elements in an alleyway on a winter's night. He was not left in circumstances similar to those in which he lived on the street—he was arrested under the cover from the rain afforded by an awning on the street front where he was found, but was left exposed to the wet and the rain in the alleyway. It is not the case that the risks to his health and safety were the same where he was left as they were in his daily existence.

I accept that Cst. Instant honestly believed that he was not placing Frank Paul at any greater risk than he encountered during his daily life on the street. I also accept that this belief was caused or promoted by his training and orientation—leading him to the

[183] Exhibit 169, p. 16.

erroneous perception that homeless chronic alcoholics possess an unusually sturdy resistance to cold and wet.[184]

I also find that Cst. Instant was, by reason of his junior rank in the paramilitary culture of the VPD, intimidated by the authority of the Jail sergeant, and reluctant to seek the intervention and assistance of senior officers or other caring organizations such as the Detox Centre, Ambulance Service or shelters. He was given orders that he did not understand, but was not equipped in his training to reject them and to seek suitable advice and assistance where it was clearly required. He did seek advice from a senior constable, but that poor advice compounded, rather than redressed, the situation.

The Aboriginal community quite understandably became concerned about the actions of the police officers involved, and became suspicious of the adequacy of the investigation. However, in my view, some of that community's more grave concerns can now be laid to rest. Specifically, Frank Paul did not die in the police wagon—the witness Patrick Lewis saw Frank Paul alive at least two hours after Cst. Instant left him in the laneway. I am also satisfied that neither ethnic discrimination nor overt hostility motivated Frank Paul's arrest, and that his Aboriginal status was not a factor in Sgt. Sanderson treating him with callous indifference. Although I have seriously criticized the decisions and actions taken by some of the police officers involved, I accept that they did not intend to cause Frank Paul harm and were not seeking to accelerate or bring about his death.

[184] See the evidence of Dr. J. Butt. Transcript, Mar. 19, 2008, pp. 13–15.

PART 4—THE RESPONSE TO MR. PAUL'S DEATH

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Interim Report of the Davies Commission of Inquiry into the death of Frank Paul

A. Introduction

In this part of my report, I turn from the events leading up to Frank Paul's death, and examine the response of various public agencies to his death.

The Terms of Reference for this commission require me:

> (b) to make findings of fact regarding circumstances relating to Mr. Paul's death, including findings of fact respecting the response of British Columbia Ambulance Service, the VPD, the BC Coroners Service, the Office of the Police Complaints Commissioner and the Criminal Justice Branch of the Ministry of Attorney General to the death of Mr. Paul.

In the discussion that follows, I have set out my findings and comments with respect to the response of these agencies to Mr. Paul's death. My organization departs from the sequence in the Terms of Reference, in that I begin with the Ambulance Service and the Criminal Justice Branch of the Ministry of Attorney General. I then turn to the VPD, the BC Coroners Service, and the Police Complaint Commissioner.

B. The Ambulance Service

Although the Ambulance Service was listed in the Terms of Reference, I have very little to say about the service except to observe that its members attended at the scene promptly after Mr. Paul's body was discovered, made efforts to resuscitate Mr. Paul and, with the concurrence of a medical doctor, determined that he was dead.

There is little more to be said about the Ambulance Service's "response" to the death of Frank Paul. While the response of the other agencies has been the subject of public discussion and criticism, no participant made any criticism of the Ambulance Service, nor do I understand its response to be controversial in any way.

Indeed, I found the Ambulance Service witnesses to be impressive. On many occasions before Mr. Paul died, they exhibited a real concern for him and engaged with him in a nonconfrontational way that permitted them to offer him some help.

I granted participant status to the Ambulance Service in our hearings, and counsel for the service assisted in organizing its witnesses and making a presentation on systemic issues relating to homeless chronic alcoholics. The Ambulance Service's involvement was

restrained, responsible and helpful. While it may appear that the inclusion of the Ambulance Service in the Terms of Reference was not necessary, I have concluded that their participation assisted my work.

C. The Criminal Justice Branch

As noted earlier, this is an interim rather than a final report. This is because the Criminal Justice Branch of the Ministry of Attorney General initiated a legal challenge to my ability to compel evidence on, and examine, its response to Mr. Paul's death. As I described earlier in this report, the BC Supreme Court dismissed the branch's challenge, and the branch's appeal of that decision was set for hearing by the British Columbia Court of Appeal in December of 2008. As I write, I do not know the outcome of that challenge.

In these circumstances, I cannot say anything about the Criminal Justice Branch's response to Frank Paul's death. Depending on the outcome of this litigation, I may need to convene additional evidentiary hearings respecting the Criminal Justice Branch's response to Mr. Paul's death. In that event, I will publish a Final Report in due course.

D. The Vancouver Police Department

1. Introduction

The discovery of Frank Paul's body in the early morning of December 6, 1998, triggered two principal responses from officers of the VPD. The first was a criminal investigation, to determine whether anyone should be held criminally liable for Mr. Paul's death. The second was a professional standards investigation, to determine whether any police officers should face internal disciplinary proceedings for their conduct relating to Mr. Paul's death. I will consider both of these investigations in this part of the report.[185]

There were other VPD "responses" as well, such as the convening of an advisory committee involving the department and members of the Aboriginal community,

[185] Although paragraph (c) of the Terms of Reference directs me to examine the rules, policies and procedures of the Vancouver Police Board, as well as the VPD, respecting police interaction with people incapacitated by alcohol or drug use, there is no reference to the Vancouver Police Board in paragraph (b), respecting the response of various public bodies to Mr. Paul's death. None of the evidence respecting the response to Mr. Paul's death raised concerns about any involvement by the board. Consequently, in this section I will focus exclusively on the activities of the VPD.

departmental efforts to ban the sale of rice wine in grocery stores, and the issue of apologizing to the Paul family. I will briefly discuss each of these later in this part.

2. The criminal investigation of Mr. Paul's death

a. Investigation at the scene

Cst. (now Sgt.) Len Callard attended the scene as part of the VPD's Forensic Identification Section. He arrived at 4:40 a.m. and took photographs of Mr. Paul's body and the general area where the body was found. He also directed that the police wagon be brought back to be photographed.[186] Cst. Callard's supervisor, Sgt. Eric Grummisch (now Inspector) also attended the scene. He testified but had a very limited recollection of the matter beyond what his notes recorded. His notes mentioned taking measurements but he was not sure what this referred to, and there was no evidence of what these measurements were or what happened to them.[187]

The Forensic Identification Section officers were not directed to obtain other forensic evidence, such as fingerprints, hair, or fibres. They did not look for impressions in the gravel or on Mr. Paul's body to understand whether Mr. Paul's body may have been moved. Cst. Callard did not recall any discussion about where Mr. Paul's body was situated. He said that, hypothetically, he would have focused on the different areas, had he been told that Mr. Paul's body may have been placed in one spot but found in another. His photographs did not focus on any particular items in the vicinity.[188] There was no examination of Mr. Paul's body or clothes to learn if they might indicate movement in the alleyway prior to his death.

Cst. Callard agreed that a Forensic Identification Section investigation into a homicide would proceed differently; it would involve a detailed sketch plan showing measurements, a careful recording of the physical location of any relevant items of evidence, and a search for relevant evidence such as fingerprints, tire marks, hair and fibre. He agreed that

[186] Transcript, Jan. 30, 2008, pp. 73–75.
[187] Transcript, Jan. 30, 2008, pp. 128–29, 133.
[188] Transcript, Jan. 30, 2008, pp. 79–80, 83–86, 88, 93.

his involvement was more a matter of recording the circumstances of a death by hypothermia, than a criminal investigation.[189]

The lead investigator in the criminal investigation was Det. Doug Staunton.[190] He served for 32 years with the VPD, beginning in 1975 and retiring at the end of 2007. He served, variously, with the Patrol Division, Recruiting, the Internal Investigation Section, Robbery, and (for the last eight years of his career) Homicide. He joined the Major Crimes Section (under which Homicide fell) in the summer of 1998, a few months before Frank Paul's death. After completing the criminal investigation into Mr. Paul's death, he prepared the Report to Crown Counsel in the matter.[191]

When Frank Paul's body was found, Det. Staunton was asked to attend at the scene as an on-call investigator who was available that night. He attended at 4:50 a.m. He observed Mr. Paul's body in the laneway behind the Detox Centre, and made some observations of the scene and the body. He was advised that Cst. Instant had described his involvement, including leaving Mr. Paul up against the side of a building. He recalled Cst. Callard being there taking photographs, but did not recall any conversation with him. At that time, in the laneway, Det. Staunton did not attach much importance to Mr. Paul's state of partial undress, nor to the fact his shoes were lying some distance from his body.[192] While I expect that Cst. Callard and Det. Staunton likely spoke, I conclude on the evidence that no direction was given to gather specific forensic information about where Mr. Paul's body was placed, where it was found, and whether it may have moved within the laneway. This was one of many missed opportunities for obtaining evidence that would have shed light on important questions surrounding Mr. Paul's death.

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[189] Transcript, Jan. 30, 2008, pp. 119–21; 123–24.
[190] Det. Staunton testified by teleconference from France. Although it was not an ideal manner of testifying, I am satisfied that he had a fair opportunity to give his evidence, and that the procedure gave Commission Counsel and counsel for the participants a reasonable opportunity to ask questions of him. Receiving his evidence in this manner did not present an insurmountable hurdle in assessing credibility, in gauging matters of subtlety, or in making findings of fact based on his testimony.
[191] Transcript, Feb. 14, 2008, pp. 2–3, 6.
[192] Transcript, Feb. 14, 2008, pp. 19–28.

Sgt. Allen Boyd from Homicide was also present at the scene early that morning. He attended at the nearby Detox Centre to speak to staff members there.[193] He had very little involvement in the investigation otherwise.[194]

b. Attendance at the autopsy

On December 8, 1998, Det. Staunton attended the autopsy.[195] His usual Homicide partner, Det. Constable Mike Cumberworth, also attended the autopsy but had no other involvement in the criminal investigation.[196] (While most homicide detectives work in teams of two or more detectives, in this case the entire matter was left to a single officer.) Cst. Callard also attended, and took photos.[197]

c. Interviewing of witnesses

Det. Staunton interviewed several civilian witnesses, including Joseph Albert (who had dealt with Mr. Paul early in the day on December 5), Patrick Lewis (who described seeing a man in the alleyway at about 10 p.m. on December 5) and Colin Robertson (who had called 911 upon discovering Mr. Paul's body early in the morning on December 6.)

d. Obtaining information from police officers

Det. Staunton did not meet and interview the many police officers, Corrections employees, and Jail staff who had relevant evidence about the Paul case. Instead, he asked them for written statements. He testified that if these people were given adequate direction on what to describe, their written report would be superior to a civilian witness's written report.[198] This may be true, but having studied the numerous short written statements provided by police officers and other non-civilians in this case, I can only say that most of them invite as many questions as they answer.

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193 Transcript, Feb. 14, 2008, p. 29.
194 Affidavit of Sgt. Boyd, Exhibit 196. Cst. Lisa James played a very minor role when she was dispatched to meet with Det. Staunton at the police station at 2120 Cambie Street. She testified that she took dictation from Det. Staunton and put together a cursory investigation report, a simple document prepared as a matter of course in the early stages of a homicide file. She did not take any statements nor verify any facts; she simply recorded what Det. Staunton set out: Transcript, Jan. 30, 2008, pp. 30–34.
195 Transcript, Feb. 14, 2008, p. 37.
196 Transcript, Feb. 14, 2008, p. 5.
197 Transcript, Jan. 30, 2008, pp. 73–75, 81–85.
198 Transcript, Feb. 14, 2008, pp. 18–19, 55–56.

Many of these reports are short and cursory. Some two-member police teams prepared reports jointly, clearly not a "best practice." I would expect a meaningful and critical investigation to require more than written statements. I would expect probing and interactive questioning to occur.

With respect to Cst. Instant, Det. Staunton testified that he would not even seek a duty report from an officer in a position such as Cst. Instant, until the officer had had the opportunity to get a lawyer and obtain legal advice, which was the practice.[199]

I heard from many witnesses whose present recollection was minimal, and who relied heavily on their initial written statements. Had those statements captured more detail or, better still, had there been transcripts of questions and answers, not only would the original investigation have been improved, but also the historic record as to the events would have been far better.

e. Other investigative steps taken

Det. Staunton undertook other investigative steps, including obtaining the CAD printouts of police calls and information from December 5–6, gathering police records on Frank Paul, obtaining a transcript of the 911 call made by Colin Robertson upon finding Mr. Paul's body, and seeking information about the taxi that carried Patrick Lewis by the alleyway after Mr. Paul had been left there.

f. Comparing this investigation to normal homicide investigations

Insp. Michael Porteous, the officer currently in charge of the VPD's Major Crimes Section (which includes the Homicide Unit), testified about the investigative steps that one would expect to see in a comprehensive investigation such as a murder case:[200]

[199] Transcript, Feb. 14, 2008, p. 57.
[200] Transcript, Feb. 21, 2008, pp. 9–19.

- The early involvement of the Forensic Identification Section to identify, obtain and preserve physical evidence including DNA, hairs, fibres, soil or debris, bullet casings, weapons, and clothing.
- The Forensic Identification Section would prepare an accurate diagram of the scene based on measurements, and would mark off important areas or items of evidence so that photographs would accurately reveal the location of different items/areas in relation to each other.
- The creation of a cordoned "crime scene," marked with police tape and carefully maintained. A person of interest would not be permitted at the crime scene and in particular up near the body in the ordinary course.
- A canvass of the neighbourhood for witnesses, other physical evidence, and video surveillance.
- As the investigation matured and a suspect was identified, police would develop a strategy to approach the person with a view to obtaining a statement and confession. Although investigators would be careful to ensure compliance with constitutional standards, they would be aggressive and strategic in attempting to interview the suspect. This may well mean that after the suspect had exercised his or her right to counsel, the police would continue trying to question them.
- The interview would be videotaped.
- In the course of interviewing important witnesses, it may be productive to confront the witness with evidence, including videotape, photographs, and statements made by others. This may prompt a reaction or revive a memory from the suspect or witness and provide information about the incident.
- Other investigative steps could be employed where further evidence was sought, including wiretaps, surveillance, and target-plant sting operations.

By contrast, there were a number of steps that Det. Staunton did not perform in the Frank Paul case:

- He did not undertake a neighbourhood canvass.[201]
- He did not search for video surveillance cameras in the relevant areas, including both the area near the Detox Centre and the area between the Jail and Dunlevy and East Hastings Streets.

[201] Transcript, Feb. 14, 2008, pp. 30–31; he noted the area was more industrial although a low-level apartment building was nearby.

- He did not locate the individuals who were inside the police wagon when Mr. Paul was taken to the laneway near the Detox Centre (although he did take steps to locate an individual who had been released from the Detox Centre after Mr. Paul had been left in the alleyway).
- He did not search the police wagon that transported Mr. Paul. The wagon might have contained evidence, such as the police form that would have been completed in order to have Mr. Paul admitted at the Vancouver Jail—which was never found.[202]

In addition, Det. Staunton never learned about one important piece of evidence—an audio recording of conversations that took place in the Jail when Cst. Instant brought Frank Paul in on December 5 and Mr. Paul was refused entry.[203] This tape was apparently misfiled, and was only found long after the criminal investigation was completed.

g. Report to Crown Counsel

Det. Staunton completed his investigative report in May 1999.[204] He testified that the aim of his report was to gather "as much information as possible ... [and] to provide the regional Crown Counsel a true and accurate fact pattern of what occurred prior to, at the time of and after the death" of Mr. Paul. He knew his report would be relied on by Crown and also by the Internal Investigations Section in assessing the disciplinary response.[205] Det. Staunton took it as his responsibility to gather the evidence for Crown Counsel, and present it in a manner that would allow Crown Counsel to assess the case, making any inconsistencies appear to the reviewing Crown. But he did not set out specific areas of inconsistency in the evidence.[206]

The report—itself an exhibit in our proceedings[207]—assembles all the various witness statements and the evidence gathered. It offers a

[202] It is possible additional evidence could have been obtained from an inspection of the police wagon that Cst. Instant drove that night. For example, in his testimony before this Commission, Cst. Instant provided a detailed account of how Frank Paul moved himself about in the wagon. A forensic inspection of the wagon may have provided evidence on this topic, either corroborating or contradicting Cst. Instant's account. Had Cst. Instant been questioned at the time, avenues of investigation such as this may have become apparent.
[203] Transcript, Feb. 14, 2008, pp. 46–47.
[204] Exhibit 91.
[205] Transcript, Feb. 14, 2008, pp. 6–7.
[206] Transcript, Feb. 14, 2008, pp. 53–54.
[207] Exhibit 91.

summary of the evidence. But it does not synthesize the information in a critical way. It does not offer any analysis of inconsistencies, improbabilities, or difficult issues in the evidence. It does not point out that Witness A's evidence is corroborated by what was said by Witness B, or by a particular item of physical or independent evidence. Likewise, it does not identify where a witness's account is inconsistent with other evidence,[208] or offer any opinion as to the possible unreliability or inaccuracy or dishonesty of any witness. It does not describe what the investigator thinks may have happened.[209] The report does not set out specific *Criminal Code* offences, describe the elements of those offences, and then undertake an analysis of how the evidence does or does not match the elements of those offences.[210] Finally, it does not include any recommendation as to whether charges should be laid and, if so, which charges and against whom.

Det. Staunton sent his report to his superiors for their review, and to Crown Counsel. Copies were also sent to the City Hall's Legal Department, to the coroners' office, and to the chief constable's office, for dissemination to the Internal Investigation and Training Sections.

Crown Counsel Austin Cullen, Q.C., subsequently asked Det. Staunton to gather some further information. By way of letter dated May 19, 1999, Mr. Cullen requested that he obtain weather reports, statements from Detox Centre staff, and also from those officers that Cst. Instant said he had spoken to at the Cobalt Hotel, including Cst. English, from whom Det. Staunton had not obtained any statement—which he acknowledged was an oversight on his part.[211] Det. Staunton tried repeatedly for four months, before obtaining Cst. English's duty report statement.[212]

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[208] This despite the fact that there were areas where Det. Staunton acknowledged inconsistencies in the evidence; see, for instance, Transcript, Feb. 14, 2008, pp. 49–50, 53–54, 70–71, 73.
[209] Transcript, Feb. 14, 2008, p. 15.
[210] Transcript, Feb. 14, 2008, pp. 17, 107–08.
[211] Transcript, Feb. 14, 2008, pp. 60–63; Det. Staunton also played the video of the Jail for Mr. Cullen.
[212] Transcript, Feb. 14, 2008, pp. 95–102.

On December 21, 1999, Crown Counsel Michael Hicks wrote to Insp. Biddlecombe, informing him that no criminal charges would be forthcoming.[213] Det. Staunton received a copy of that letter.

h. The "neutrality" of Reports to Crown Counsel in police-related deaths

There was considerable evidence about the "neutral" Reports to Crown Counsel that investigating officers prepared in police-related death cases. In his testimony, Det. Staunton stated: "That was a practice that the Major Crime investigators followed. *We didn't make judgments.* We would just gather as many and all the facts that were available" (emphasis added).[214]

Det. Staunton's understanding, a view shared within the department, was that if the neutral report left questions unanswered, Crown Counsel was free to come back to the investigator to request further work or more input. But the assessment as to "whom to believe" was to be left to the Crown, based on a report summarizing evidence in a disinterested manner.[215]

This approach to the Report to Crown Counsel was not the product of any written policy or directive. Instead, it was a practice employed in such cases, which I understand remains in effect today.[216] The rationale behind the neutral Report to Crown Counsel would appear to be driven by a concern about perceived bias or conflict of interest: if the investigator recommended no charge, this could be perceived as favouring the member of the same police force whose conduct was under examination.

Insp. Porteous expressed the concern about conflict of interest in this way:

> ... it's given to Crown Counsel to ensure that there is a neutral third party that makes the determination as to whether or not charges do or

[213] Transcript, Feb. 14, 2008, p. 65. The actual letter is not in evidence because of the Criminal Justice Branch's claim of privilege and immunity.
[214] Transcript, Feb. 14, 2008, p. 9.
[215] Transcript, Feb. 14, 2008, p. 10.
[216] Evidence of D. Staunton, Transcript, Feb. 14, 2008, p. 13; Affidavit of A. Boyd, Exhibit 196, para. 12; evidence of Insp. Porteous, Transcript, Feb. 21, 2008, pp. 34–36.

> do not get laid so that there's not any kind of perception of bias or subjectivity on the part of the police.[217]

He added that, given the "extreme public scrutiny" over the issue of criminal charges for police-related deaths, this mechanism is in place to provide for an independent assessment by Crown Counsel. The police "want to have an independent agency such as Crown Counsel [determine whether to charge] without being influenced by the police department in making their decision."[218]

In Part 6, I will discuss in more detail the concern about conflict of interest that arises when an officer of one police department conducts a criminal investigation into the conduct of another officer from that same department.

i. Identifying inconsistencies in the evidence

I also heard considerable evidence about whether an officer investigating a police-related death should identify, in the Report to Crown Counsel, inconsistencies in the evidence. Former Chief Constable Terry Blythe testified that he would expect an investigator to communicate any inconsistencies in the evidence to Crown Counsel.[219] Similarly, Insp. Porteous expected that any inconsistencies should be highlighted and discussed in the Report to Crown Counsel, even for a police-related death case.[220] When such inconsistencies in the Frank Paul case were pointed out to Det. Staunton during the evidentiary hearings, he accepted that he should have caught them.[221]

The "Neutral Report" practice, unique to police-related death cases, stands in sharp contrast to the normal practice, where one would expect the police to offer analysis and to share their views as to whose statements were corroborated and whose were contradicted.[222] While it is an

[217] Transcript, Feb. 21, 2008, pp. 34–35.
[218] Transcript, Feb. 21, 2008, p. 51.
[219] Transcript, Feb. 27, 2008, pp. 17–21.
[220] Transcript, Feb. 21, 2008, pp. 37–38.
[221] Transcript, Feb. 14, 2008, pp. 75–76.
[222] Det. Staunton agreed with this: Transcript, Feb. 14, 2008, pp. 9–10. See also the evidence of Insp. Porteous, Transcript, Feb. 21, 2008, pp. 33–35.

inevitable reality of criminal investigations that there will be inconsistencies in the evidence,[223] I would nonetheless expect major inconsistencies—of the sort that undermine a key witness's account—to be the subject of critical comment in the investigative report.

Clearly, an investigator who has gathered the evidence first-hand and has generally spoken to witnesses himself, will be in a better position to identify concerns about reliability or credibility than a Crown prosecutor reading quiet words on a page. The analogy that springs to mind is that of a legal appeal: the court of appeal reading a transcript cannot engage in the same meaningful way with matters of credibility, whereas the trial judge who sat near the witness and observed him or her testifying can.

j. Reliance on written duty reports from police officers

It is clear that in the Frank Paul case Det. Staunton did not personally interview the two key police officers, Cst. Instant and Sgt. Sanderson, relying instead on written duty reports they prepared. This reflected the department's usual practice in such cases. Former Chief Constable Terry Blythe testified that the practice was for investigators to rely on written statements by officers: "That's how they conduct their business and that's what we condoned in the department." His understanding was that this was done for reliability and expediency, but also because the police union had insisted that statements would be provided to internal discipline investigators by way of written statements rather than oral statements or interviews.[224]

Insp. Porteous, head of the VPD's Major Crimes Section, confirmed that reliance on duty reports for police statements appears to be the norm.[225] Indeed, the approach is so widely employed that investigators will generally *not even ask* for an interview, expecting that the officer will decline and instead only agree to provide a duty report.[226]

[223] Transcript, Feb. 14, 2008, p. 79.
[224] Transcript, Feb. 27, 2008, pp. 17–21; see also Affidavit of A. Boyd, Exhibit 196, para. 14.
[225] Transcript, Feb. 21, 2008, pp. 26–27.
[226] Transcript, Feb. 21, 2008, p. 28.

3. My conclusions about the criminal investigation

Based on this review of the evidence, I have reached several conclusions respecting the VPD's investigative response to the death of Frank Paul.

First, very soon after the discovery of Mr. Paul's body, the department realized that it was involved in a serious police-related death, which necessitated a criminal investigation by its Major Crimes Section to ascertain whether any police officer or officers should be charged criminally. This stands in sharp contrast to the evidence of the Forensic Identification Section officer, that his involvement was more a matter of recording the circumstances of a death by hypothermia, than a criminal investigation.

Second, many parts of the criminal investigation were, in my respectful opinion, inadequately performed:

- The Forensic Identification Section officers did not perform many of the tasks that they would normally perform in a homicide investigation, such as preparing a detailed sketch plan showing measurements, recording the physical location of relevant items of evidence, or searching for relevant evidence such as fingerprints, tire marks, hair and fibre.
- The investigating officers did not:
    - give appropriate instructions to the forensic team about specific forensic information respecting the location of Mr. Paul's body and whether it had been moved.
    - locate or interview several relevant non-police witnesses.
    - search for video surveillance cameras that may have recorded relevant information.
    - interview numerous police officers, Corrections employees and Jail staff, relying instead on written statements.
    - insist on interviewing the two key police officers, Cst. Instant and Sgt. Sanderson.

Third, the investigating officer did not, in his Report to Crown Counsel:

- identify inconsistencies in the evidence, or offer views on the credibility of various witnesses.

- identify specific *Criminal Code* offences that he had considered, or relate specific pieces of evidence to what must be proved for any given offence.

- include his opinion as to whether criminal charges were warranted in this case and, if so, against whom and for what offences.

Fourth, while these investigative inadequacies concern me, I am much more troubled with the department's organizational environment that provided for this type of investigation to occur. Put bluntly, the most serious flaw in this criminal investigation was in not conducting it in the same manner that the department would investigate any major crime that did not involve police officers.

While I feel obligated to identify the specific inadequacies that permeated this criminal investigation, I decline to find fault with the conduct of any individuals involved in the investigation. I do so because I am satisfied that they acted in accordance with departmental policies and practices (some written and some not) that prescribed very different procedures for the investigation of police-related deaths. The two most glaring inadequacies in the department's approach to the investigation of police-related deaths were the practice of not interviewing the officers involved, and the preparation of "neutral" Reports to Crown Counsel.

Fifth, it is not enough to identify the inadequacies in an individual criminal investigation that occurred nearly a decade ago, and then move on to other issues. What this inquiry's review has revealed are systemic flaws in the manner in which the VPD conducted criminal investigations of police-related deaths at that time, which continue today. As long as these systemic flaws (grounded in conflict of interest) remain, there is a risk that the criminal investigation of other police-related deaths will be inadequately conducted. If that happens, justice will not be done and, equally importantly, the public will lose confidence in the administration of criminal justice. For these reasons, I will explore in Part 6 the issue of the criminal investigation of police-related deaths, and will make recommendations for major reforms.

4. The professional standards investigation of Mr. Paul's death

a. The *Police Act*'s police complaints scheme

Under the provincial *Police Act*, when a member of the public makes a complaint about the conduct of a municipal police officer, the complaint is

investigated by that officer's police department. In the case of the VPD, such professional standards investigations are conducted by the Professional Standards Section (known as the Internal Investigation Section when the Frank Paul investigation was carried out in 1999).

The *Police Act* contemplates three types of complaints—public trust complaints, internal discipline complaints and service or policy complaints. A public trust complaint (the most serious) refers to conduct that constitutes a breach of the *Code of Professional Conduct Regulation* and that does one of the following:

- causes or has the potential to cause physical or emotional harm or financial loss to any person,
- violates any person's dignity, privacy or other rights recognized by law, or
- is likely to undermine public confidence in the police.

An internal discipline complaint means a complaint that relates to the acts, omissions or deportment of a police officer that falls short of a public trust complaint, and is normally dealt with under the collective agreement's grievance procedure.

A service or policy complaint means a complaint to the effect that a police department's policies or procedures are inadequate, and is dealt with by the police board.

In the case of a public trust complaint (as in the Frank Paul case), the complaint must, if not resolved informally, be investigated. If the investigator recommends the imposition of disciplinary or corrective measures, and the chief constable agrees, then a confidential pre-hearing conference may be held, to determine whether the officer is willing to admit a public trust default and, if so, what disciplinary measures the officer is willing to accept. If a public trust complaint is not resolved at a pre-hearing conference, then a more formal discipline proceeding must be convened.

Ultimately, it is the chief constable (as the discipline authority under the *Police Act*) who imposes disciplinary or corrective measures, usually based on the recommendation of the investigating officer.

b. The investigation by Sgt. Andrew Hobbs

The professional standards investigation relating to Mr. Paul's death was originally assigned to Sgt. (now Superintendent) Hobbs, on May 20, 1999.[227] He reviewed the Major Crimes report that Det. Staunton had prepared.

Sgt. Hobbs noted that there was no statement from Cst. English, the officer with whom Cst. Instant had conversed at the Cobalt Hotel shortly before Cst. Instant left Mr. Paul in the laneway near the Detox Centre. Sgt. Hobbs tried to contact Cst. English on several occasions to have him provide a statement.[228]

Sgt. Hobbs also made efforts to learn if Mr. Paul had an address in Vancouver. He did not find one.[229] At that time no decision had been made as to whether a coroner's inquest would be held, and so Sgt. Hobbs inquired of the Coroners Service.

In the course of reviewing Det. Staunton's file, Sgt. Hobbs concluded "that there were public interest issues that should be investigated under the *Police Act*." To initiate that process and to notify the PCC that the Internal Investigation Section was investigating the matter, Sgt. Hobbs completed a Form 1 complaint form and sent it to the PCC.

Sgt. Hobbs then sent a copy of the Notice of Complaint to Sgt. Sanderson and Cst. Instant, to make them aware of the Internal Investigation Section's involvement.[230] He characterized the complaint as a "public

[227] At the time there were, I believe, eight sergeants in the Internal Investigation Section, plus a staff sergeant, with an inspector in charge. Transcript, Feb. 11, 2008, p. 4, and Feb. 13, 2008, p. 2.
[228] Transcript, Feb. 13, 2008, pp. 12–16; Sgt. Hobbs was unaware, at the time, that Crown Counsel had also asked of Det. Staunton that he obtain a statement from Cst. English. Cst. English's statement, ultimately, was addressed to both Det. Staunton and Sgt. Hobbs, dated Sept. 9, 1999: Exhibit 110, Tab D.
[229] Transcript, Feb. 13, 2008, p. 17.
[230] Exhibit 110, Tab B.

trust complaint" and received confirmation that the PCC agreed with that characterization.[231]

This was the extent of Sgt. Hobbs's involvement in the file. He testified that although he raised concerns about the two officers' conduct, he never formed any firm view on what should happen to them ultimately.[232]

c. The investigation by Sgt. Donald Boutin

Sgt. Boutin assumed conduct of the Frank Paul professional standards investigation from Sgt. Hobbs on September 14, 1999.

Sgt. Boutin (now retired) had been with the VPD since 1975, serving in a variety of positions, including Patrol; the Integrated Intelligence Unit; Recruiting; Robbery; Witness Protection; and Homicide. He spent the last three years of his career (from 1999 to 2003) in the Internal Investigation Section.[233]

Sgt. Boutin[234] outlined the ordinary way in which a professional standards file would be handled. The investigator would review the file and the facts, interview the citizen who had brought the complaint, and proceed with the investigation. As an investigator, Sgt. Boutin would notify the PCC, and complete the investigation to the point of determining whether disciplinary or corrective measures were appropriate. The investigator's report would be forwarded to the inspector in charge of the Internal Investigation Section, who would either order more investigation or concur in the investigator's recommendation. Once the inspector approved the report, it would go to the chief constable, and disciplinary or corrective measures would be imposed. Upon completion of the department's disciplinary processes, the matter would be referred to the PCC for his review.[235]

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[231] Transcript, Feb. 13, 2008, pp. 27–29; Exhibit 110, Tab C.
[232] Transcript, Feb. 13, 2008, p. 32.
[233] Transcript, Feb. 11, 2008, p. 2.
[234] See also the evidence of A. Hobbs, Transcript, Feb. 13, 2008, pp. 3–12; Sgt. Hobbs's description of the IIS process reflected Sgt. Boutin's, including his discussion of police duty reports.
[235] Transcript, Feb. 11, 2008, pp. 4–5.

According to Sgt. Boutin, the procedure would be somewhat different when there had been a fatality (which might lead to an inquest) or a criminal investigation into an officer's conduct (which might lead to criminal charges against the officer). In such cases, the Internal Investigation Section would be apprised of developments involving both the Crown and the coroner, and would hold off on its investigation until after the decision was made about criminal charges and/or a coroner's inquest. The reason for this, Sgt. Boutin testified, was that these other processes took precedence over the Internal Investigation Section investigation, and if a criminal trial or coroner's inquest were to take place, the section's investigation would make use of the information arising from them.[236]

When Sgt. Boutin assumed conduct of the Frank Paul file in September 1999,[237] the professional standards investigation had to be completed by January 2000, in order to comply with the six-month limit set by the *Police Act*. Since Sgt. Boutin did not know whether a coroner's inquest would be held or whether criminal charges would be laid, he applied for and received an extension of his investigation, until April 2, 2000.[238]

Sgt. Boutin testified that he relied on Det. Staunton's criminal investigation report. Normally, Sgt. Boutin explained, the report prepared by a homicide detective would be comprehensive, and it would be unusual to conduct a further investigation to address questions about discipline under the *Police Act*.[239]

In the course of an Internal Investigation Section investigation, Sgt. Boutin testified, the investigator would normally command the officer involved to produce a duty report. The expectation was that the duty report would address all relevant points, and in Sgt. Boutin's experience, they were comprehensive.[240] In the Frank Paul case, of course, such

[236] Transcript, Feb. 11, 2008, pp. 5–7, 9.
[237] Evidence of A. Hobbs, Transcript, Feb. 13, 2008, p. 31.
[238] Exhibit 110, Tabs H, J, O. Sgt. Boutin learned on December 10, 1999, of the decision not to hold a coroner's inquest, and on Jan. 7, 2000, that there would be no criminal charges: Transcript, Feb. 11, 2008, pp. 24, 28–29.
[239] Transcript, Feb. 11, 2008, pp. 10–11.
[240] Transcript, Feb. 11, 2008, pp. 12–14.

reports had already been prepared for the criminal investigation. Sgt. Boutin did not request further reports, or interviews, with Sgt. Sanderson or Cst. Instant.

d. The determination of an appropriate disciplinary response

In developing his recommendation on whether disciplinary or corrective measures should be imposed and, if so, what they should be, Sgt. Boutin reviewed Det. Staunton's file and photos of the Jail (although no video and no audio). He made notes about the evidence. He observed that these two officers had no history of needing to be disciplined. Sgt. Sanderson had old complaint files that had not resulted in any disciplinary sanction, but Sgt. Boutin did not look at them. He did, however, look at each officer's human resources (personnel) files.[241] He reviewed Sgt. Sanderson's second written statement on the Paul matter, dated February 17, 2000.[242] He also sought information from Environment Canada about the weather conditions on December 5–6, 1998.[243]

Sgt. Boutin exchanged correspondence with counsel for Cst. Instant. He asked four questions:

1. Was the ambulance service contacted, in order to assess Mr. Paul?
2. Was the Detox Centre asked about taking him?
3. Was Saferide considered as an alternative?
4. Was Sgt. Sanderson consulted about the change of location for the breach of the peace?[244]

Counsel for Cst. Instant responded with four "no" answers, and nothing more. There was no further discussion.[245]

Although the memo containing the four questions was also addressed to Sgt. Sanderson, Sgt. Boutin was not sure he actually sent it to

[241] Transcript, Feb. 11, 2008, pp. 45–50.
[242] Transcript, Feb. 11, 2008, p. 51.
[243] Transcript, Feb. 11, 2008, pp. 50–51; Exhibit 110, Tabs P, U.
[244] Exhibit 110, Tab J.
[245] Transcript, Feb. 11, 2008, p. 39; Exhibit 110, Tab R.

Sgt. Sanderson. He felt he already knew the answers to those questions, given the brevity of Mr. Paul's stay at the Jail. In any case, he did not receive any reply from Sgt. Sanderson.[246]

Sgt. Boutin testified that when he considered the appropriate disciplinary response for the officers involved in Mr. Paul's death, he contemplated the nine categories available under s. 19(1) of the *Code of Professional Conduct Regulation*. These options range from dismissal at the high end of the range, down to verbal or written reprimands.

He noted that suspensions without pay amounted to "level 7 out of 10 in terms of severity, which was quite an unusual amount of punishment."[247] The *Police Act* provided for up to five days' suspension (but no more), and Sgt. Boutin did not feel this case involved the worst sort of conduct, warranting the maximum length of suspension.[248]

Sgt. Boutin said that, in addition to this official catalogue of options, he also considered whether an unofficial kind of response, known within the VPD as "management advice," might be best. Management advice, from what I understand, involved an informal response, not provided for in the *Police Act*, whereby the officer would be advised he or she had made a mistake, and told not to make the mistake again. It is, in Sgt. Boutin's words, "just an administrative slap on the wrist within the VPD. It doesn't have anything to do with the *Police Act*."[249]

Sgt. Boutin explained that someone else (he did not recall who) suggested the "management advice" approach, and he initially agreed it would be adequate.[250] Indeed, on January 18, 2000, Insp. John Eldridge (the head of the Internal Investigation Section) signed a letter (that Sgt. Boutin testified he may have drafted) to investigator Bill MacDonald in the Office of the PCC, suggesting that a "management advice" response was

[246] Transcript, Feb. 11, 2008, pp. 37–38.
[247] Transcript, Feb. 11, 2008, p. 44.
[248] Transcript, Feb. 12, 2008, p. 167.
[249] Transcript, Feb. 12, 2008, p. 165.
[250] Transcript, Feb. 11, 2008, p. 18–20.

anticipated.[251] Upon looking at the file in greater detail, however, Sgt. Boutin concluded it would not be appropriate.[252]

Sgt. Boutin explained the process that Internal Investigation Section investigators would employ in order to arrive at the appropriate disciplinary response for an officer's misconduct. There were informal meetings within the section, at which various files would be the subject of roundtable discussions. There was no body of precedents or cataloguing of past disciplinary responses.[253]

In his final report to Insp. Eldridge, dated January 10, 2000 (it should have read February 10, 2000), Sgt. Boutin faulted Sgt. Sanderson for failing to have Mr. Paul medically assessed (either by Jail nurses or Ambulance Service personnel), and for failing to consider some other kind of shelter, whether through Saferide or the Detox Centre. By "breaching" Mr. Paul rather than engaging in such alternatives, Sgt. Boutin reasoned, Sgt. Sanderson did not exercise due diligence in ensuring the safe custody of a prisoner in his charge.[254] He recommended a two-day suspension without pay.

Sgt. Boutin faulted Cst. Instant for changing the location of the breach of peace authorization, without consultation. In addition, he found that Cst. Instant had placed himself in direct personal charge of Mr. Paul and, like Sgt. Sanderson, had failed to consider medical attention and the proper kind of shelter for Mr. Paul.[255] He recommended a one-day suspension without pay.

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[251] Transcript, Feb. 11, 2008, pp. 33–35; Exhibit 110, Tab H. The IIS appeared to change views soon afterward; eight days later another letter from Insp. Eldridge to Mr. MacDonald indicated a *Police Act* form of action was under consideration: Exhibit 110, Tab I.
[252] Transcript, Feb. 11, 2008, pp. 18–20.
[253] Transcript, Feb. 11, 2008, pp. 42–44; see also Evidence of Sgt. Hobbs, Transcript, Feb. 13, 2008, pp. 33–35 (referring to "the corporate memory of people that have been there for some time," and noting the fact that the *Police Act* was new, although he felt it did not mean a more or less harsh disciplinary regime than before). Former VPD Chief Terry Blythe described this process as well: Transcript, Feb. 27, 2008, pp. 4–5; he sat in on weekly meetings with the IIS investigators and supervisors.
[254] Transcript, Feb. 11, 2008, p. 59; Exhibit 110, prior to Tab A, p. 6.
[255] Transcript, Feb. 11, 2008, p. 60; Exhibit 110, prior to Tab A, p. 6.

For both officers, Sgt. Boutin noted that he did not conclude there was malice or culpable intent.[256]

In addition, Sgt. Boutin made a recommendation to the department's Planning and Research Section,[257] that it consider:

1. including the Saferide protocol referenced at page 22 of Det. Staunton's report in VPD's *Regulations and Procedures Manual*; and

2. that a Bulletin Notice regarding the importance of safety in cold weather when alcoholic or no fixed address prisoners are released be published for all members' information.

Sgt. Boutin explained that while he received some correspondence from the Planning and Research Section, he never got a confirmation that his proposals had been adopted.[258]

e. Chief Constable Blythe's acceptance of Sgt. Boutin's recommendations

In his testimony, former Chief Constable Terry Blythe described his involvement in the Paul disciplinary file. As chief constable, he was the discipline authority under the *Police Act*. He relied on Sgt. Boutin's final report. He did not review any videos of Mr. Paul in the Vancouver Jail and did not recall seeing any photographs of the Jail. He agreed that, for his role as discipline authority, he also relied on there having been a thorough investigation by Det. Staunton. He did not identify any issue about the two officers' honesty, but agreed that if such a concern arose it would introduce a separate and serious question and would call for a more severe penalty.[259]

In his handwritten notation dated February 15, 2000, Chief Blythe indicated his agreement with Sgt. Boutin's report and indicated: "The

[256] Transcript, Feb. 11, 2008, p. 60.
[257] Transcript, Feb. 11, 2008, pp. 24–25, 57; Exhibit 110, prior to Tab A, p. 7 (numbering added).
[258] Transcript, Feb. 12, 2008, pp. 185–86; Exhibit 110, Tabs X, GG.
[259] Transcript, Feb. 27, 2008, pp. 7–16, 23, 45–46.

penalty must align with similar fact evidence [*sic*] and penalty recommendations."[260]

f. The two officers' acceptance of the disciplinary measures

On March 17, 2000, Cst. Instant accepted the proposed disciplinary measures, a one-day suspension without pay.

Sgt. Sanderson attempted, through his agent, to reduce the proposed penalty, but was unsuccessful.[261] On June 20, 2000, Sgt. Sanderson accepted the proposed disciplinary measures, a two-day suspension without pay.[262]

The Internal Investigation Section closed its file on June 28, 2000, and advised the PCC.[263]

5. My conclusions about the professional standards investigation

Based on this review of the evidence, I have reached several conclusions respecting the VPD's professional standards response to the death of Frank Paul.

First, I commend Sgt. Hobbs for realizing the seriousness of the Frank Paul incident, completing a Form 1 complaint and delivering it to the PCC. Without this notification, the PCC may not have been aware of this police-related death until months later, which would have seriously undermined his office's ability to perform its civilian oversight role. The current scheme for inquiring into allegations of police misconduct is entirely complaint driven, and when there is a police-related death in which the deceased has no close family who might file a complaint, there is a risk that the PCC will not be alerted for many months, if at all. As I see it, this is part of a much larger problem with the current legislative scheme for the investigation of complaints against police officers, which I will explore in more detail in Part 7.

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[260] Exhibit 110, prior to Tab A (notation on memo from Insp. Eldridge to Chief Blythe dated Feb. 14, 2001). In the absence of any system to organize and understand past sanctions in similar cases, and given how new the *Police Act* then was, it would have been difficult to ensure that the penalties in the Paul case were consistent with others across the province.
[261] Transcript, Feb. 11, 2008, p. 63.
[262] Transcript, Feb. 12, 2008, pp. 154–55.
[263] Transcript, Feb. 11, 2008, p. 67; Exhibit 110, Tab FF.

In Part 7 of this report I will examine the current practice of a home police department conducting professional standards investigations in police-related death cases, and will recommend significant reforms.

Second, in this case, those conducting the professional standards investigation relied inordinately on the criminal investigation, which I have earlier characterized as inadequately performed. While the criminal investigation report was a valuable resource for those conducting the professional standards investigation, it should not have been seen as a substitute for a probing investigation into the professional duties imposed on police officers in these circumstances.

Third, the investigators' failure to interview the two officers whose conduct was central to the investigation, relying instead on their written duty reports, left many questions unanswered, and could lead the public to conclude that this was a pro forma investigation. I recognize that the investigators in this case were following departmental policy (the result, I believe, of contentious negotiations between management and the police union), but the public is not well served when those implicated in a police-related death have no duty to cooperate, other than filing a written duty report. In Part 7 of this report, I will discuss my understanding of a police officer's professional obligation to cooperate in a professional standards investigation (as distinct from a criminal investigation), which in my view includes a duty, when requested, to be interviewed by the investigating officer and to answer the officer's questions.

Fourth, I am concerned that members of the Internal Investigation Section had to resort to roundtable discussions, in order to formulate appropriate discipline recommendations to the chief constable. While section 19(4) of the *Code of Professional Conduct Regulation* gives some guidance as to the aggravating and mitigating circumstances that must be considered in determining just and appropriate disciplinary or corrective measures, it would have been helpful if the officers had some record of previous decisions (within the department and across the province) in comparable cases, to give them a sense of what was appropriate and to achieve some degree of consistency.

Fifth, with respect to the specific disciplinary and corrective measures imposed in this case, I have two concerns:

- The anomaly created by a narrow range of potential suspension was made apparent when several witnesses from both the VPD and the OPCC struggled to explain why the periods of suspension in these cases were appropriate by reference to the maximum possible suspension of five days. Viewed objectively, a five-day suspension would not be regarded as a severe penalty or lengthy period of time. It was suggested that this was because if a lengthier suspension was appropriate, then dismissal should follow. I do not agree, and this case demonstrates that the disciplinary tools available for the mistakes that had been identified and acknowledged were simply inadequate.

- The penalties imposed in this case focused exclusively on punishment. While not inappropriate, the penalties ignored serious errors in professional judgement and the need for more understanding of the needs of (and perhaps human compassion for) chronic alcoholics. Section 19(2) of the *Code of Professional Conduct Regulation* states that

> an approach that seeks to correct and educate the police officer concerned takes precedence over one that seeks to blame and punish, unless the approach that should take precedence is unworkable or would bring the administration of police discipline into disrepute.

Both officers, who were dealing on a daily basis with homeless chronic alcoholics like Frank Paul, could have benefited from remedial training about such people's incapacities and needs, and the importance of bringing a nonjudgemental professional attitude to their treatment of them.

Sixth, apart from the inadequacies in this particular professional standards investigation, the legislative scheme under which this investigation took place is premised on a home police department investigating its own officers. This gives rise to the same "police investigating themselves" concern I raised when examining the department's criminal investigation. As I will explore in more detail in Part 7, it is, in my view, a fundamentally flawed model because of the inherent conflict of interest, and needs substantial reform.

6. The Vancouver Police Department's relationship with the Aboriginal community

I would like to comment briefly on one other "response" by the VPD to the death of Frank Paul.

In 2006, the department initiated a process with the Aboriginal community in a bid to build bridges and address issues that had given rise to mistrust on the part of First Nations citizens. In his testimony, Insp. John De Haas of the department's Diversity and Aboriginal Policing Section described this process, which came to be called the VPD–Vancouver Aboriginal Community Joint Working Committee.

The committee followed up on recommendations made by the Coroners Service in 1999, arising out of Mr. Paul's death, which had not yet been addressed. One of the issues that concerned the Aboriginal community was the fact that the Jail policy required medical assessment only for persons who had been booked into custody, which, of course, would not capture a person in Mr. Paul's situation. The committee facilitated a change in this policy.

The committee's work culminated in a public forum on April 28, 2007, at a school in Vancouver. The forum included First Nations cultural traditions, an apology by VPD Chief Constable Jamie Graham, a presentation on the Paul case by Insp. De Haas, and informal dialogue about police relations and community sentiments.[264] Although this was a worthy initiative, the process was not well-received by the Aboriginal community, for several reasons. It inaccurately portrayed Mr. Paul as having been left in a protected, well-lit and well-travelled laneway, under cover.[265] Also, Insp. De Haas's PowerPoint presentation used a photograph of the entrance to the Detox Centre, implying that this was where Mr. Paul had been left, rather than a few hundred feet away, around the corner and down the laneway to the west.[266]

7. Apologizing to the Paul family

Section 19(5) of the *Code of Professional Conduct Regulation* states in part:

> Nothing in this Code prevents a chief constable ... from ... issuing an apology on behalf of the municipal police department concerned or, with the consent of the police officer concerned, on behalf of both the department and the police officer....

[264] Transcript, Feb. 21, 2008, pp. 138–63; Exhibits 147, 148, 149.
[265] Transcript, Feb. 14, 2008, pp. 166–67.
[266] Transcript, Feb. 14, 2008, pp. 168–70.

Although the VPD offered no apology to the Paul family, during Chief Constable Blythe's tenure,[267] for its treatment of Frank Paul, Chief Constable Graham did offer an apology in 2004.[268]

In his testimony, Cst. Instant said that he long wished to apologize to the Paul family, but was concerned that the venue at our public hearings was not ideal. He explained:

> I think an apology to the family should be done in person, because part of that process of apologizing is an exchange of information, questions why I did this, why I did that. I've asked Mr. Crossin, my lawyer, to look into this possibility in the Fall of 2007, to make arrangements to meet with the family and to do just that.[269]

I was impressed with Cst. Instant's sincerity, and commend him for this intention which, I trust, will offer some comfort to the Paul family and will assist the family and Cst. Instant in bringing closure to this tragedy. I suggest that the department consider the broad issue, and develop a policy that would permit an apology to be provided in such a situation

E. The BC Coroners Service

1. The role of the BC Coroners Service

The BC Coroners Service is governed by the provincial *Coroners Act*. The current Act,[270] enacted in 2007, made significant changes to the Act[271] that was in force during the Coroners Service's response to the death of Frank Paul.

Both Acts provide for a chief coroner for the province, regional coroners and, within each region, coroners. They specify numerous circumstances in which a death must be reported to the Coroners Service.

When a death is reported, the coroner is required to conduct an investigation, and then decide whether to proceed by way of a Judgment of Inquiry or by an inquest. A Judgment of Inquiry is a written report prepared by the coroner,

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[267] Transcript, Feb. 27, 2008, pp. 66–67.
[268] Exhibit 147, Tab 23, letter of Apr. 28, 2004, to City Manager, City Of Vancouver; see also Tab 7.
[269] Transcript, Jan. 11, 2008, p. 54.
[270] See *Coroners Act*, [Statutes of British Columbia] S.B.C. 2007, c. 15, which came into force on September 26, 2007.
[271] See *Coroners Act*, [Revised Statutes of British Columbia] R.S.B.C. 1996, c. 72.

whereas an inquest is a hearing, convened by the coroner before a jury and open to the public, at which witnesses testify. In either case, the objective is to address five issues:

1. Who was the deceased?
2. When did the deceased die?
3. Where did the deceased die?
4. How did the deceased die? Although the coroner's process does not find fault, it does result in a classification of the cause of death, such as accident, suicide or homicide (which does not imply criminal culpability).
5. What recommendations may help prevent similar deaths in the future?

2. The Coroners Service's response to Mr. Paul's death[272]

a. Attendance at the scene of Mr. Paul's death

Although Mr. Paul's body was discovered in the alleyway near the Detox Centre at approximately 2:30 a.m., Donna Lister,[273] a coroner in the Vancouver office, did not attend at the scene until about 6:30 a.m. The evidence is not clear when she was first notified to attend the scene.

Ms. Lister recalled that it was really cold, there were police at the scene, and the area was taped off. Mr. Paul's body was cold and his clothing was wet and askew. He was not wearing his shoes, but they were nearby. She took three Polaroid photographs. She directed that the body be removed for autopsy.[274]

b. Preparation of a preliminary investigation report

Ms. Lister prepared a preliminary investigation report, although it was under the name of Regional Coroner Jeannine Robinson,[275] who had the

[272] British Columbia has long used a lay coroner system in which the government officials who attend at the scene of a death are not physicians or pathologists but trained lay people drawn from other backgrounds.
[273] In 1998, Ms. Lister was a relatively junior coroner, with previous experience as a VPD officer and as a member of the provincial Ministry of Social Service's welfare-fraud group. See Transcript, Nov. 30, 2007, pp. 1–2.
[274] Transcript, Nov. 30, 2007, pp. 2–9.
[275] Exhibit 53 (also Exhibit 90, Tab 4).

authority to sign such a report.[276] This report relied upon information given by the police. Ms. Lister did not recall the police directing any particular questions or issues to her. For her, the scene was similar to others in which a homeless person was found dead in an alleyway in the Downtown Eastside.[277]

Ms. Lister requested that an autopsy be done and that toxicology tests be conducted. She then moved to considering what recommendations she might make about how to prevent a similar death in the future.[278]

c. The autopsy

Ms. Lister testified that the coroner does not attend the autopsy; rather:

> The coroner is just there to be the eyes for the pathologist at the scene, and the pathologist takes over from the point that the body arrives at the morgue.[279]

Dr. Laurel Gray testified, and her post-mortem report was entered as an exhibit. Dr. Gray is an eminent pathologist with many years of experience. Understandably, given the passage of time and the number of matters she has dealt with, she did not hold any detailed recollection about the Paul case. Dr. Gray conducted the post-mortem examination on Frank Paul the morning of December 8, 1998. She testified that in such examinations, the pathologist would seek to determine the cause of death, and consider if there were illnesses or injuries that played a role. The autopsy would also permit the collection of evidence, including trace evidence from the body, DNA, and fluids for toxicology testing.[280]

Dr. Gray relied on the coroner's indication of the date of Mr. Paul's death (December 6, 1998), and did not express an opinion as to the exact hour of his death. She noted arthritis that had distorted Mr. Paul's ankles and hands, which would have affected his locomotion and dexterity. Although Mr. Paul had injuries, none appeared new or significant. She noted

[276] Transcript, Jan. 23, 2008, p. 54.
[277] Transcript, Nov. 30, 2007, pp. 10–12, 15.
[278] Transcript, Nov. 30, 2007, p. 30.
[279] Transcript, Nov. 30, 2007, p. 9.
[280] Transcript, Jan. 16, 2008, pp. 1, 8–9; Exhibits 84, 85, and 86.

lividity on his back, suggesting the blood pooled there as he lay on the ground. She also noted two areas indicating injury to the brain; she suggested these would not be expected to impair Mr. Paul's cognition, and may have been related to seizures. Mr. Paul's liver was in surprisingly good condition.[281]

Dr. Gray recorded Mr. Paul's blood-alcohol level to be .29 grams percent, which represents more than three times the legal limit for driving a car, and would render a non-alcoholic person staggering drunk or unconscious.[282] The toxicology report gave three different alcohol levels: .29 grams percent in the blood, .39 grams percent in the vitreous fluids and .41 grams percent in the urine, suggesting that the alcohol was in the post-absorption phase at the time of death, and would have been significantly higher some hours prior to his death.[283]

In her report, Dr. Gray described the cause of death as "[h]ypothermia due to or as a consequence of acute alcohol intoxication."[284] In her testimony, she indicated that there was no specific pathological finding to indicate hypothermia was the cause of death. Rather, that conclusion was the product of both the circumstances in which the body was found, and the exclusion of other possible causes of death. Asked to comment on the interplay between these two, she testified:[285]

> Mr. Paul was quite intoxicated with alcohol at the time of his death. The amount of alcohol and the other bodily fluids would indicate that while he hadn't consumed alcohol for a short period of time, at some time earlier the alcohol level would have been significantly higher. We know that alcohol dilates the blood vessels on the surface of the skin. We alluded to that before, the flushed face, the red ears, and that would be heat lost by the radiation. Further heat would be lost very rapidly through wet clothing. Heat would be lost with every expiration of breath. Heat would be lost from his body onto whatever surface he was lying on outside. Heat would be lost from his body with a downward gradient to whatever the ambient temperature was.

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281 Transcript, Jan. 16, 2008, pp. 24–25, 34–48.
282 Transcript, Jan. 16, 2008, pp. 49–51, 55, 58.
283 Exhibit 90, Tab 3.
284 Transcript, Jan. 16, 2008, pp. 19–23; Exhibit 85 (also Exhibit 90, Tab 44).
285 Transcript, Jan. 16, 2008, p. 23.

Having set out Dr. Gray's autopsy and post-mortem report, this is a convenient juncture for me to describe the evidence provided by forensic pathologist Dr. John Butt, who testified at the request of Cst. Instant. Dr. Butt did not take issue with Dr. Gray's conclusion that the cause of death was hypothermia, associated with both cold exposure and alcoholic intoxication. He indicated that it was not possible to determine at what point Mr. Paul became hypothermic; there was no core temperature taken and the short video of Mr. Paul being dragged in the Jail did not provide this information.[286]

Dr. Butt suggested there was "a reasonably good possibility that he would have seizures."[287]

Dr. Butt described two medical conditions that would often arise for chronic alcoholics such as Mr. Paul. One is peripheral neuritis, an inflammatory reaction within the nerve that may impair the person's sensory response, making them less aware of pain, for example. The second is Wernicke-Korsakoff Syndrome, which he described as involving: cerebellar degeneration; ataxia of gait (lack of balance on one's feet); confusion; restricted eye movement; mental derangement; acute short-term memory loss; lethargy; and difficulties speaking and communicating. The lack of balance would often cause the person to broaden his or her stance for stability, but it would not affect the arms; the person might retain good arm strength and coordination of the upper body. Wernicke-Korsakoff Syndrome is thought to be related to vitamin-B_1 deficiency and is found in alcoholics. The presentations described just now are not triggered by alcohol and do not vary with whether the person is drunk or sober; instead, they are a function of the syndrome itself.[288]

d. The decision not to hold an inquest

The Coroners Service had to decide whether Mr. Paul's death should be dealt with by way of a written Judgment of Inquiry, or by an inquest. Under the *Coroners Act* then in force, section 9(3) required an inquest for

[286] Transcript, Mar. 19, 2008, pp. 7–11; Exhibit 161, pp. 2–3.
[287] Transcript, Mar. 19, 2008, p. 32.
[288] Transcript, Mar. 19, 2008, pp. 13, 16–19, 40, 45–52, 93.

a person who died "while detained by or in the actual custody of police." If, at the precise moment of death, the deceased person was detained or in the custody of police, an inquest had to be held. If not, an inquest was discretionary; i.e., one could be held if the coroner chose to do so.[289]

When the holding of an inquest was discretionary, the Coroners Service's *Policy and Procedures Manual* provided guidance by outlining the criteria for this determination.[290] It set out a number of considerations to inform this decision, including:

- public interest in the case;
- the necessity of compelling witnesses to give evidence;
- the need to clarify evidence or obtain more evidence; and
- the concern of the deceased's family, agencies, and interest groups.

The regional coroner, Jeannine Robinson,[291] testified that she met with Ms. Lister on December 7, 1998, the day after Mr. Paul's body had been found.

Several days later she met with Larry Campbell (chief coroner at the time), regarding the circumstances of Mr. Paul's death. Ms. Robinson testified that in this early conversation, she expressed her view that it may be appropriate for the Paul case to go to an inquest. According to her, Mr. Campbell indicated the death was not technically "in custody," and therefore she should carry on with the investigation. She testified that he indicated that: "really it wasn't an in-custody death and ... we would not be proceeding with inquest."[292]

When Mr. Campbell testified, he did not recall this conversation, but accepted Ms. Robinson's evidence that it had occurred. He testified that the investigation was at an early stage and he was not making any final

[289] For example, section 20(1) of the Act then in force stated: "If a death has occurred other than in a police prison or lock-up or under circumstances that require an inquest, instead of summoning a jury, the coroner may make an inquiry into the death of the deceased as the coroner considers proper."
[290] Exhibit 90, Tab 45; see also Tab 54 (current policy).
[291] Ms. Robinson, a registered nurse for 37 years, served in the Coroners Service from 1990 to 2006. In 1998–99 she was the regional coroner for the metro Vancouver region. See Transcript, Jan. 23, 2008, pp. 47–49.
[292] Transcript, Jan. 23, 2008, pp. 71–73 and p. 75 (quotation); see also p. 144.

determination on the matter; he was providing advice rather than issuing a directive.[293] Ms. Robinson, however, testified that she took this as a directive.[294] I accept that this conversation did take place as described by Ms. Robinson, and that she understood Mr. Campbell's statements being a directive not to hold an inquest. Mr. Campbell acknowledged that the context in which an inquest was considered at the time was that very few inquests were ordered on a discretionary basis; accordingly, if one was not required in general, it would have been unusual to order one.[295]

Notwithstanding that conversation, Ms. Robinson still felt that an inquest should be held. Her concern was that this man, left alone and cold in an alleyway, should not have his death ignored. In her view, his death could be considered an "in custody" death, and it would be easier to start from the premise that an inquest was necessary, and approach the case on that footing. However, having been advised it would not proceed to inquest, she conveyed this to Ms. Lister and to Sherryl Yeager, the deputy regional coroner.[296]

e. Preparation of the Judgment of Inquiry

Ms. Robinson assumed responsibility for preparing the Judgment of Inquiry, because Ms. Lister was leaving the Coroners Service.[297] In preparing this report, Ms. Robinson built on Ms. Lister's work. She met with Ms. Lister and Ms. Yeager and engaged in some research and analysis of the issues arising. She reviewed, and relied heavily on, Det. Staunton's investigation report and Dr. Gray's post-mortem, and watched the video showing Mr. Paul at the Jail.[298] She testified that there were elements of the police report she did not accept at face value, such as the statement of Corrections officer Greg Firlotte. However, she did not ask the police to interview or re-interview witnesses, although this was a step she had taken on occasion.[299]

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293 Transcript, Jan. 25, 2008, pp. 3–8, 41–42.
294 Transcript, Jan. 23, 2008, p. 75.
295 Transcript, Jan. 25, 2008, pp. 85–87, Exhibit 93, p. 5.
296 Transcript, Jan. 23, 2008, pp. 73–76.
297 Transcript, Jan. 23, 2008, p. 67.
298 Transcript, Jan. 23, 2008, pp. 77–83.
299 Transcript, Jan. 23, 2008, pp. 78–80; Transcript, Jan. 24, 2008 pp. 15–16.

Even at this stage, there was still some discussion about whether to hold an inquest. Ms. Robinson had Ms. Yeager contact Deputy Chief Coroner Norm Leibel, to double-check that the view from above remained that the matter would be dealt with by way of a Judgment of Inquiry rather than an inquest. Although she had previously wanted an inquest, her view changed. Asked why, she testified[300]:

> Because throughout the course of the investigation I was able to satisfy the mandate of the *Coroners Act*. I was able to identify who the person was, how he died, when he died, by what means, and I was able to classify the death. I didn't think there would be anything further to be gained by going to inquest because we had all of the information and all of the evidence needed to conclude the file.

Ms. Yeager, who was the deputy regional coroner in 1998, also testified. Although she could recall little of her involvement, and her notes were lost, she did recall her conversation with Mr. Leibel in the spring of 1999, as to whether the Paul matter should go to an inquest. She called him (while present with Ms. Lister) to ask whether it should proceed to inquest. She testified:[301]

Q And what do you recall of the conversation with Mr. Leibel?

A I recall that we discussed whether or not it should go to inquest; that we discussed there was no media attention on the file; that we'd had no contact or involvement with the family; that it was a preventable death and we can make recommendations and that we could proceed with a good Judgment of Inquiry. And Norm was—Norm was in agreement with that and that's how we proceeded after that point.

Q Was it your view that there should be an inquest into the death of Mr. Paul in the spring of 1999?

A It was my view that a Judgment of Inquiry would do the same job.

Ms. Robinson testified that, in preparing the Judgment of Inquiry, she wanted to formulate recommendations to avoid a similar death in the future. The recommendations had to be practical, appropriate, and

[300] Transcript, Jan. 23, 2008, pp. 85–86. Mr. Leibel had no recollection of this conversation but accepted Ms. Yeager's evidence that it took place: Transcript, Jan. 29, 2008, p. 10.
[301] Transcript, Jan. 24, 2008 pp. 139–45 (quotation p. 145).

directed to an agency that had the power to make changes, since they were advisory rather than enforceable.

The Judgment of Inquiry was completed on November 8, 1999. Ms. Robinson categorized Mr. Paul's death as an "accident" rather than "homicide," and set out several recommendations, directed to the VPD, including:[302]

1. Any staff coming into contact with persons brought into the Jail should be knowledgeable of and educated in the procedures contained within the VPD *Regulations and Procedures Manual* (manual). In particular, staff should be familiar with the policy for a breach of the peace, section 10.4 where the supervisor shall consider the person's safety and well-being with respect to that person's removal from the scene, incarceration and subsequent release from the Jail.

2. The manual should be amended to include a requirement that if a person remains under arrest or not, he/she should be medically assessed prior to release from the facility. This should not be done by non-medical staff.

3. The manual should be amended to include a requirement that if the person to be released is not in medical distress but obviously not fully capable of caring for themselves, arrangements for Saferide or any similar service should be made to ensure that the person has the option of being taken home or to a shelter, particularly during inclement weather.

4. A record of any lasting medical problems on persons who are well known to the system should be kept and accessed upon the person being booked into the facility. This could be flagged under the person's name on the computer.

The Judgment of Inquiry concluded with this remark:[303]

> As a result of a series of non-medical judgments and lack of clear policy, this individual was released into inclement weather. Mr. Paul did not have the ability to get himself to a place where he could be protected from the weather. Persons obviously at risk should be

[302] Exhibit 90, Tab 43.
[303] Exhibit 90, Tab 43.

protected and assisted to a safe environment upon their release from custody.

In her testimony, Ms. Robinson explained why she categorized Mr. Paul's death as an accident. The category of "accidental deaths" would include unintentional or unexpected injuries, including where someone died from complications due to an accident. It may include a car accident, an unintended drug overdose or a workplace industrial accident. The Coroners Service's category of "homicide," on the other hand, applies for deaths due to an injury intentionally inflicted by the action of another person. The designation as a "homicide" is not intended to imply fault or blame, and is very different from what criminal lawyers, and indeed most members of the public, would understand to be a "homicide."[304]

3. The notification of Mr. Paul's next of kin of his death

a. The duty to notify the next of kin of a person's death

It is my understanding that, at the time of Mr. Paul's death, the VPD and the Coroners Service had a protocol with respect to notifying the family of the deceased of a death. The responsibility to ensure that the next of kin was notified fell to the Coroners Service. However, in practice, given the resources of police agencies and their ability to perform an in-person notification in most cases, the actual notification was undertaken by the police.[305] It is clear that in this case the Coroners Service did not notify Mr. Paul's next of kin.[306]

The current chief coroner, Terry Smith, was unequivocal about the responsibility to notify and consult with the next of kin. He testified:[307]

Q On your review of the file did it appear as if the Coroners Service had notified the next of kin or spoken with the next of kin

[304] Transcript, Jan. 23, 2008, pp. 49–51.
[305] Evidence of J. Robinson, Transcript, Jan. 23, 2008, pp. 58–60, 106; Evidence of Cst. Dickhout, Transcript, Feb. 13, 2008, pp. 150–51, 178; Evidence of R. Rothwell, Transcript, Jan. 31, 2008, pp. 61–63, 69.
[306] Evidence of J. Robinson, Transcript, Jan. 23, 2008, pp. 104, 110–12, 118–19; Evidence of S. Yeager, Transcript, Jan. 24, 2008, p. 149; Evidence of D. Lister, Transcript, Feb. 26, 2008, pp. 50–51.
[307] Transcript, Jan. 28, 2008, p. 12; see also p. 93. Mr. Leibel also expressed regret over the service's failure to contact the Paul family: Transcript, Jan. 29, 2008, pp. 27, 55.

respecting the file generally and the decision of whether to hold an inquest rather than proceed to a Judgment of Inquiry?

A It did not appear that we had contacted them.

Q And what's your view of the coroner's responsibility in relation to obtaining the input from next of kin?

A That's an absolute must, and it's something that ought to have been done without fail in this case, it wasn't, and while I wasn't there at the time, on behalf of the British Columbia Coroners Service I would offer our sincere apologies to the Paul family for that oversight.

b. The Vancouver Police Department's media briefing respecting Frank Paul's death

In our hearings, the suggestion arose that Mr Paul's death had been kept from the public, as well as Mr. Paul's family. In light of this, it was important to receive evidence pertaining to the VPD's media briefing in 1998.

Cst. (now Sergeant) Anne Drennan was the VPD's media liaison officer between 1994 and 2005. In her testimony, she described the media briefing process employed by the department at the time of Mr. Paul's death. She would obtain information both through a daily briefing in the chief's office, and by contacting different areas of the department to get information.

Cst. Drennan did not recall the Frank Paul briefing, but her records indicated that on December 7, 1998, she provided information to journalists at the daily press briefing. She announced that a Native Indian male, aged 47, was deceased. The next day the *Vancouver Sun* included a short item referring to the death, indicating that the police had not released the deceased man's name, as they were trying to notify the next of kin.[308] On December 11, 1998, she publicly identified the deceased as Frank Paul, 47 years old, of "no fixed address." She stated that there was

[308] Transcript, Feb. 13, 2008, pp. 134–35; Exhibit 120. Cst. Drennan also made note that a VTV reporter had contacted Det. Staunton about the Paul matter: Transcript, Feb. 13, 2008, p. 105.

no clear cause of death, and that toxicology results would be some weeks away.[309]

Cst. Drennan testified that it would be very rare to identify a deceased person, knowing that the next of kin had not been notified. This would happen on occasion, but was a last resort. Coroners and liaison officers would first try to locate and notify the next of kin, failing which they might turn to her and ask her to release some basic information.[310] The evidence does not permit me to conclude why Mr. Paul's name was disclosed by the VPD, but there is no suggestion in the evidence that would support an inference that notification had occurred by the date of the second briefing.

c. The Vancouver Police Department's notification of Mr. Paul's next of kin

Det. Staunton, who conducted the criminal investigation into Mr. Paul's death, testified that he did not have any dealings with the next of kin, which was unusual for his homicide files. He had information from an old arrest sheet about an address in Maine, U.S.A., but believed the matter of notification was dealt with by the VPD's coroner liaison officer and the Coroners Service.[311]

According to Regional Coroner Jeannine Robinson, at the time of Mr. Paul's death the VPD maintained a coroner liaison officer, who would locate and contact the next of kin in those situations where the next of kin was not readily identified by officers attending at the scene of the death.[312]

In 1998 and 1999, Cst. Dickhout served as the VPD's coroner liaison officer. He testified that the Coroners Service and the department jointly funded his position. His duties included reviewing sudden-death files and liaising with the Coroners Service. He would review sudden-death files as they came in to check that the investigator had notified the next of kin of the death. If not, the coroner liaison officer would assist the coroner in

309 Transcript, Feb. 13, 2008, pp. 88–92, 95–101, 137.
310 Transcript, Feb. 13, 2008, p. 103.
311 Transcript, Feb. 14, 2008, pp. 33–34.
312 Transcript, Jan. 23, 2008, pp. 58–60.

locating, identifying, and notifying the next of kin. Ideally, notification would be done in person, by having local police attend the next of kin, but in some cases it might be handled by phone, especially where inquiries had to be made.[313]

Cst. Dickhout did not have any recollection of the Paul matter. In reviewing documents, he agreed it was clear that Det. Staunton had not notified Mr. Paul's family. A possible next of kin might have been Mary Anne Akerson, whose name had appeared in Jail booking sheets in the early and mid-1990s. The documents filed also indicated that on January 11, 1999, a James Ackerman at the Big Cove Band in New Brunswick had been notified at a specified telephone number, but it was not clear who had put that information on the database system or who had made the notification. Cst. Dickhout could not recall making the notification himself,[314] and agreed that his role may have been contacting the next of kin in order to arrange the return of Mr. Paul's body, as distinct from contacting them to tell them of his death.[315]

d. The Paul family's recollection of being notified of Frank Paul's death

At the time of Mr. Paul's death, his sister Frances Jourdain lived in Maine, U.S.A. She and her husband (Dan Jourdain) testified by teleconference from their home.

Mr. Jourdain recalled taking a phone call from a person who told him they were from the RCMP. The person gave a rank and name, and told Mr. Jourdain that Mr. Paul had been run down by a hit-and-run driver, and was deceased. The caller asked him to pass the message on to his wife, Frances. Mr. Jourdain did not recall the name or rank of the person calling, but wrote down "RCMP" on a sheet of paper—he did not know what the initials stood for. Mr. Jourdain had no recollection of when this call was made, nor could he provide other details about the call.[316] He testified that when Frances got home, he told her what the caller had told

313 Transcript, Feb. 13, 2008, pp. 149–53.
314 Transcript, Feb. 13, 2008, pp. 151, 158–60, 162–64.
315 Transcript, Feb. 13, 2008, p. 176.
316 Transcript, Feb. 26, 2008, pp. 55–58.

him, and asked her to call the number that the caller had left. She did so and, after she hung up, he recalled her saying that she had to call the coroner to make arrangements to have Mr. Paul's body transported.[317]

In her testimony, Ms. Jourdain confirmed that the police informed her that Frank Paul had been killed as a result of a "hit-and-run" accident. She also testified that they provided her with a phone number to contact the coroner to make arrangements for the body to be shipped home.[318]

Ms. Jourdain testified that she then called the Big Cove Band office in New Brunswick. She spoke to Chief Levi, who said that he would take care of everything. She thought she probably also spoke to Peggy Clement, her cousin. It was not until three years later that Ms. Jourdain learned, from Ms. Clement, that Frank's death was not the result of a hit and run.[319]

4. The 2002 next of kin notification complaint

In 2002, a member of the legislative assembly with an interest in the Frank Paul matter, Tony Bhullar filed a *Police Act* complaint, which included an allegation that the Paul family had been told that Frank Paul had been killed in a hit-and-run accident involving a taxicab.

Sgt. Robert Rothwell initiated an investigation to ascertain what had been done to notify the next of kin, and what information the Paul family had been given. Det. Cst. Cheryl Leggett subsequently assumed conduct of this investigation. The investigation involved speaking with people in New Brunswick and in Vancouver, including members of the Paul family, the Big Cove Band Council, the VPD, and the RCMP in New Brunswick, where Mr. Paul's family lived. It also involved trying to track down records in the possession of the VPD, the RCMP, or the Coroners Service that might describe what the family had been told. No such records could be found. Further, no VPD officers or RCMP members could describe whether they told members of the Paul family anything and, if so, what.[320]

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317 Transcript, Feb. 26, 2008, pp. 57–58.
318 Transcript, Feb. 26, 2008, pp. 67–70.
319 Transcript, Feb. 26, 2008, pp. 72–74, 77.
320 Transcript, Jan. 31, 2008, pp. 122–23.

Following the investigation, Sgt. Rothwell dismissed the complaint summarily. He concluded that there was no credible basis for believing that Mr. Paul's family or the Big Cove Band were the recipients of deceitful information from the police.[321] His reporting letter, which relied on information given by Det. Cst. Leggett, stated that the department's investigation had been "frustrated by faded memories and an unwillingness by the members of the Big Cove Band Council and relatives of Mr Paul, some of whom were following the advice of counsel representing them in a civil claim for damages, to cooperate."[322] I will comment on these assertions later in this part.

In their testimony, Sgt. Rothwell and Det. Cst. Leggett stated that the department's investigation was not able to conclude whether either the VPD or the RCMP had any contact with any member of the Paul family. The department could not conclude that accurate information was given; nor could it conclude that inaccurate information was not given. The investigation was unable to determine the origin of Mr. Bhullar's allegation that Frank Paul had been hit by a taxi. It did conclude that Cst. Dickhout had made contact with the Band Council, specifically Brian Solomon, and had told him that Mr. Paul had "frozen to death."[323]

5. Subsequent requests for an inquest

Having discussed the notification of Mr. Paul's next of kin, I turn now to requests that the Coroners Service reconsider the holding of an inquest.

In late 2000, the PCC (Don Morrison) asked the Coroners Service to convene an inquest into Mr. Paul's death.[324] He renewed that request in 2001. In 2004, a different PCC (Dirk Ryneveld) made a similar request.

The legislation in force at those times[325] authorized the chief coroner to re-open a matter if new evidence had arisen or been discovered after the Judgment of Inquiry was concluded. The test for the chief coroner was whether the evidence

[321] Transcript, Jan. 31, 2008, p. 23; Exhibit 110, Tab XX (letter from R. Rothwell to B. Murphy, October 10, 2002).
[322] Transcript, Jan. 31, 2008, pp. 25–26.
[323] Transcript, Jan. 31, 2008, pp. 27, 12–13, 41–43.
[324] Transcript, Jan. 23, 2008, pp. 146–47.
[325] *Coroners Act*, R.S.B.C. 1996, c. 72, s. 20(6).

was substantial and material; and whether it existed at the time or was not discovered at the time.

In his testimony, Chief Coroner Smith recalled the 2001 request, in which Mr. Morrison focused on the ability of a coroner to cross-examine witnesses under oath. Mr. Smith reviewed the file and spoke with Ms. Robinson, who had prepared the Judgment of Inquiry. He concluded that there was nothing in the *Coroners Act* providing the authority to re-open the case. He conveyed this conclusion to Mr. Morrison and to the Solicitor General's ministry.[326]

With respect to the 2004 request, Chief Coroner Smith asked Ms. Robinson to review several binders of documents that the PCC had sent to him, in order to assess whether there was new evidence that would warrant ordering an inquest. She concluded that there was no such evidence; she was already aware of the Jail video showing Mr. Paul being dragged in and out of the Jail. In her view there was nothing to be gained, at this point, by going to inquest.[327]

Chief Coroner Smith testified that, despite his view that the Paul case was the sort of case he would have felt appropriate for an inquest in the first instance, he did not have the jurisdiction to re-open the matter and convene an inquest.[328]

6. My conclusions about the response of the Coroners Service

Based on this review of the evidence, I have reached several conclusions respecting the Coroners Service's response to the death of Frank Paul.

First, my ability to ascertain what happened has been seriously hampered by the incomplete documentary record. Numerous Coroners Service witnesses described having made notes or generated materials that would have provided an accurate and timely recording of their thinking and the steps they took. For reasons unexplained, many of these Coroners Service records are now missing, including, for example, Regional Coroner Jeannine Robinson's notes of her conversation with the chief coroner about going to inquest.[329] These notes would be expected

[326] Transcript, Jan. 28, 2008, pp. 4–9.
[327] Transcript, Jan. 23, 2008, pp. 96–98; see also Evidence of T. Smith, Transcript, Jan. 28, 2008, pp. 25–29.
[328] Transcript, Jan. 28, 2008, pp. 31–33, 70, 86.
[329] Transcript, Jan. 23, 2008, pp. 65–67.

to shed light on a very important conversation, in a context where one witness (Ms. Robinson) had some recollection but the other (Larry Campbell) had none. In addition to missing notes, significant records that the Coroners Service was required to create are no longer available.[330]

Because of this incomplete documentary record, I feel compelled to exercise caution in how I articulate the conclusions that follow.

Second, one of the central issues facing the Coroners Service was whether an inquest was mandatory in these circumstances. That revolved around the wording of the legislation, which required an inquest if Frank Paul had died "while detained by or in the actual custody of police." It is clear that he had been detained and was in the actual custody of police up until the moment when Cst. Instant placed him in the alleyway. This gives rise to a question. Given Mr. Paul's inability to care for himself, should he be considered to remain in the VPD's custody, even though he was no longer in the wagon?

This was referred to by some as "constructive custody," but another way of looking at the same question would be to say that actual custody does not terminate in the case of a person incapable of caring for themselves, unless they are given over to another's care. There appeared to be no consideration of this interesting and difficult question.

Given these unique facts, it was an issue that warranted careful and thoughtful consideration (and perhaps referral to legal counsel for advice). The evidentiary record does not satisfy me that adequate consideration was given to this issue.

Third, even if the circumstances did not make an inquest mandatory, should the chief coroner have exercised his discretion to call an inquest? The consensus of several key witnesses is that an inquest should have been called:

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[330] Evidence of N. Leibel, Transcript, Jan. 29, 2008, pp. 4–9; Mr. Leibel fairly said that the lost materials were "an embarrassment" for the Coroners Service (p. 9). He had to retrieve some official forms—the medical certificate and shipping certificate—from Vital Statistics.

- Then-Chief Coroner Campbell agreed during his testimony that, with the benefit of hindsight, the Paul case would have been better handled by way of an inquest than by a Judgment of Inquiry,[331]

- Deputy Chief Coroner Norm Leibel agreed that, with the benefit of hindsight, he would "absolutely" take the Paul case to inquest,[332] and

- Current Chief Coroner Smith testified that if circumstances like the Paul case arose today, the matter would proceed to inquest. He indicated that the Coroners Service would feel obligated to take the case to inquest to satisfy the public's demand to know the facts of the matter, in a public forum.[333]

In 1999, the Coroners Service's *Policy and Procedures Manual* identified the criteria that should be considered, in deciding whether to order an inquest, and those criteria included the public interest and the concern of the deceased's family. Given the inadequate state of the evidentiary record, I cannot say whether the Coroners Service gave adequate consideration to the public interest. However, the service clearly did not take into account the concerns of Mr. Paul's family, since the service had not notified the family of his death.

Fourth, in my view it was reasonable for the Coroners Service to classify the death as "accidental" rather than "homicide." Based on the evidence before the Coroners Service at that time and the evidence I now have, the service was entitled to conclude that no one had intentionally caused Mr. Paul's death.

Fifth, Ms. Robinson's four recommendations were, in my view, appropriate. In particular, I endorse her second recommendation (medical assessment prior to release from the Jail), and her fourth recommendation (making arrangements for Saferide or other similar service to ensure that people being released who are not fully capable of caring for themselves are taken home or to a shelter, especially in inclement weather).

Sixth, the Coroners Service has acknowledged that it did not fulfil its obligation to notify the Paul family of Frank Paul's death. I commend Chief Coroner Smith for apologizing to the Paul family during his testimony. As I discussed earlier,

[331] Transcript, Jan. 25, 2008, pp. 85, 8.
[332] Transcript, Jan. 29, 2008, p. 24.
[333] Transcript, Jan. 28, 2008, pp. 15–16.

notification of the next of kin is a crucial precondition to deciding whether to order an inquest, given that the concerns of the deceased's family must be taken into account in making that decision.

Seventh, I am satisfied that in February 1999, the RCMP contacted Frances Jourdain, Frank's sister, and told her that he had died in a hit-and-run accident. We know that Frank Paul did not die from a hit and run, but we do not know where that inaccurate information originated. There is some documentary evidence that the VPD may have contacted the Big Cove Band on January 11, 1999, about Mr. Paul, but the record is not clear respecting who did so or what was said. I conclude it is more likely than not that it was the RCMP, acting on behalf of the VPD, who contacted the Jourdains. (The detail about Don Jourdain not knowing what "RCMP" stood for, strikes me as the sort of detail that would not be recalled in error.) This would make sense, as it was commonplace to have local police forces handle such notifications outside Vancouver.

The evidentiary record does not disclose any attempt by the VPD, before January 11, 1999, to notify the Paul family of Frank Paul's death. However, we do know that on December 11, 1998, five days after Frank Paul's death, the VPD publicly reported his death and identified him by name. Again, because of the incomplete documentary record, we do not know why his name was released, if the family had not yet been notified of his death.

I make one additional observation about the VPD's December 11, 1998 media briefing, during which the briefing officer stated that there was no clear cause of death. The autopsy had been conducted on December 8, and Dr. Gray attributed death to "hypothermia due to or as a consequence of acute alcohol intoxication." While I do not know what information the briefing officer had at the time of the December 11 briefing (and thus do not mean to criticize what she said), the effect of the briefing was that the public was misled, both as to the cause of death and to the fact that by then the department was treating it as a police-related death and that, consequently, the Major Crimes Section was conducting a criminal investigation.

Eighth, the inadequacy of the documentary record prevents me from drawing any conclusions respecting the adequacy of the 2002 professional standards investigation into Mr. Bhullar's complaint. I do observe, however, that the known

facts do not support several statements in the officer's report to the effect that the Paul family or the Big Cove Band were unwilling to cooperate, the nature of legal advice the Paul family had received or the existence of any civil claim.

Ninth, it would not be appropriate for me to second-guess the chief coroner when, in his exercise of discretion, he concluded that he did not have jurisdiction to re-open the Frank Paul file and order an inquest, as requested by two different police complaint commissioners. This is particularly so when the evidence established to my satisfaction that the Coroners Service saw and acted upon the Jail videotape in forming the conclusions reached in the Judgment of Inquiry.

F. The BC Police Complaint Commissioner

1. The legislative scheme

As I discussed earlier in this part, when a complaint is made about the conduct of a municipal police officer,[334] members of that officer's home police department carry out the professional standards investigation. If, as a result of that investigation, it is concluded that the officer has violated the *Code of Professional Conduct Regulation,* the chief constable (as discipline authority under the *Police Act*) imposes disciplinary or corrective measures.

The 1998 *Police Act* established an independent PCC, as a civilian overseer of a municipal police department's investigation of professional standards complaints. The PCC is selected by, and reports annually to, the Legislative Assembly rather than the Executive Branch.

The investigating police department must notify the PCC when it receives a complaint. While the PCC's office may monitor the police department's investigation, it normally does not play an active role until it receives the department's final report on how the complaint was investigated and dealt with. At that stage, the PCC's office may review the adequacy of the police department's professional standards investigation, following which the PCC may:

[334] The police complaint scheme established by Part 9 of the *Police Act*, R.S.B.C. 1996, c. 367 applies only to British Columbia's 11 municipal police departments. Complaints against RCMP officers, who police the remainder of the province, are regulated federally.

- take no further action, in which case the police department's investigation, and any disciplinary or corrective measures imposed, are final (s. 59.1(4)),
- order that the police department provide further reasons justifying the particular disciplinary or corrective measures imposed (s. 59.1(2)(a)),
- order an external investigation by another municipal police department (s. 55.1), or
- order a public hearing (s. 60).

A public hearing may arise in two situations. First, the PCC must order a public hearing if the disciplined police officer (the respondent officer) requests one, and a disciplinary or corrective measure more severe than a verbal reprimand has been imposed. Second, the PCC may order a public hearing in any other case, if the commissioner determines that "there are grounds to believe that a public hearing is necessary in the public interest (s. 60(3)(b))."

In deciding whether a public hearing is necessary in the public interest, the PCC must consider all relevant factors including, without limitation, the following:

(a) the seriousness of the complaint;

(b) the seriousness of the harm alleged to have been suffered by the complainant;

(c) whether there is a reasonable prospect that a public hearing would assist in ascertaining the truth;

(d) whether an arguable case can be made that

  (i) there was a flaw in the investigation,

  (ii) the disciplinary or corrective measures proposed are inappropriate or inadequate, or

  (iii) the discipline authority's interpretation of the *Code of Professional Conduct Regulation* was incorrect; and

(e) whether a hearing is necessary to preserve or restore public confidence in the complaint process or in the police (s. 60(5)).

A public hearing is conducted by an adjudicator, who must be a retired judge. Generally, witnesses are compellable to testify and produce records. However, the rule is different for the respondent officer. Section 61.1(1) states that:

A respondent who is subject to a public trust complaint is not compellable to testify as a witness at a disciplinary proceeding, or at a public hearing, in respect of that complaint, but an adverse inference may be drawn from the respondent's failure to testify at the discipline proceeding or at the public hearing.

At the conclusion of a public hearing, the adjudicator may:

- find that all, part or none of the alleged discipline default has been proved on the civil standard of proof,
- impose any disciplinary or corrective measures that may be imposed by a discipline authority, and
- affirm, increase or reduce the disciplinary or corrective measures proposed by the discipline authority (s. 61(6)).

2. Commissioner Morrison's handling of the Frank Paul complaint

a. The police complaint commissioner's receipt of the Frank Paul complaint

Don Morrison served, between 1998 and 2002, as British Columbia's first PCC. He first became aware of the Frank Paul complaint in August 1999 when his office received the Form 1 complaint form that Sgt. Hobbs of the VPD had prepared. Mr. Morrison confirmed the characterization of the complaint as a public trust complaint. Mr. Morrison testified that at this stage he was not concerned about the file; he did not see anything indicating that the VPD was not doing its job.[335]

In late 1999, Mr. Morrison approved a request from Insp. Eldridge for a three-month extension of the VPD's professional standards investigation. The department's practice of awaiting decisions from the coroner (respecting whether an inquest would be held) and from the Criminal Justice Branch (respecting whether criminal charges would be approved) meant that it could not complete its investigation within the six-month period mandated by the *Police Act*.

[335] Mr. Morrison acknowledged in his testimony that he had little recollection of conversations related to the Frank Paul complaint, independent of the documents recording those discussions. He did not prepare notes or memos recording his thinking about the file: Transcript, Mar. 12, 2008, pp. 100–107.

In seeking this extension, Insp. Eldridge canvassed the possibility of a "management advice" response to the Paul matter. Management advice was an informal process outside the *Police Act*, which did not result in the imposition of any disciplinary or corrective measures. Mr. Morrison testified that he was not satisfied with such an approach, and the department did not pursue it.[336]

b. Assignment of the Frank Paul file to Mr. MacDonald

In June 2000, Commissioner Morrison received the VPD's final report of its professional standards investigation, in which Sgt. Sanderson had been given a two-day suspension without pay and Cst. Instant had been given a one-day suspension without pay. Mr. Morrison was aware, at this juncture, that the Coroners Service had decided against an inquest, and that the Crown had decided not to proceed with criminal charges. He testified that, in his view, his options were to confirm the discipline imposed, review it with a possibility of calling a public hearing, or to collect more information. He concluded that further information was needed,[337] and the file was assigned to Bill MacDonald, one of the office's investigators.

c. Mr. MacDonald's file review and report

Mr. MacDonald, who joined the Office of the PCC (OPCC) as an investigator in July 1998, testified that his first involvement in the Paul file was to review the VPD's criminal and professional standards investigations, and prepare a "file review" memo on the Paul matter.

In his August 2000 memo, he came down strongly in favour of ordering a public hearing. He articulated the recommendation following the criteria set out in s. 60(5) of the *Police Act* for the ordering of a public hearing. He recommended that Cst. English be added as a respondent, and set out an analysis of which sorts of disciplinary defaults were alleged. He focused on inconsistencies, particularly in the accounts given by Cst. Instant and Sgt. Sanderson. His view was that incongruities in the evidence could be explored in a public hearing. While the respondent officers would not be

[336] Transcript, Mar. 12, 2008, pp. 37, 39–42; Exhibit 152, Tabs 8, 9, 10.
[337] Transcript, Mar. 12, 2008, pp. 46–49.

compellable, experience suggested that such officers do take the stand and testify. On this basis he felt a public hearing would lead to the truth of what happened.[338]

d. Mr. Morrison's consideration of Mr. MacDonald's report

According to Mr. MacDonald, there was a meeting in September or October 2000, at which there was a discussion about how to proceed in the Frank Paul matter. He testified that Mr. Morrison had already expressed concern that too much time had passed for a public hearing to take place.[339]

According to Mr. Morrison, he wanted more evidence before making the decision on whether to call a public hearing.[340] There was agreement to obtain further information, including an analysis of Cst. Instant's statement, and an expert opinion from Dr. James (Rex) Ferris, a forensic pathologist.[341]

e. Dr. Ferris's opinion letter

In November 2000, Dr. Ferris delivered his opinion letter to the PCC. In it, he reviewed a series of documents from the police investigation report, including Dr. Laurel Gray's post-mortem report.

In his written report, Dr. Ferris agreed with Dr. Gray's conclusion that Mr. Paul's death was a consequence "of excess alcohol consumption and exposure to cold in the period shortly before his death." He went on to opine as follows:

> In the case of Frank Paul, it is likely that his fatal hypothermia developed over the course of many hours and there seems no doubt that he was suffering from hypothermia when he was removed from the Jail.
>
> The video photographs show that Mr. Paul was unable to stand and had to be dragged in and out of the elevator. It is my opinion that at

[338] Exhibit 155, Binder 1B, Tab 20 (also at Exhibit 152, Tab 16); Evidence of W. MacDonald, Transcript, Mar. 18, 2008, pp. 39–52; Evidence of D. Morrison, Transcript, Mar. 12, 2008, pp. 111–18.
[339] Transcript, Mar. 18, 2008, pp. 53–55.
[340] Transcript, Mar. 12, 2008, p. 149; Transcript, Mar. 13, 2008, pp. 66–67.
[341] Transcript, Mar. 12, 2008, pp. 49–52, 121–22.

> the time of his discharge from the Police Jail, Mr. Paul was totally incapable of taking care of himself.
>
> I do not believe that at the time he was left in the alley that Mr. Paul was capable of being walked to the side of the lane. I think it is likely that he was dragged to the wall and then position [*sic*] on the ground with his back against the wall.
>
> The position of Mr. Paul's clothing at the time he was found dead is consistent with his body being dragged and it is unlikely that Mr. Paul was capable of any significant voluntary movement after he was left in the alley.[342]

Dr. Ferris concluded that Mr. Paul's death could have been prevented if he had been medically assessed at the Jail, and if he had not been removed from the Jail and left in an alley exposed to rain and cold.[343]

In his testimony (by video conference from New Zealand), he expressed the opinion that Mr. Paul's appearance in photographic stills extracted from the Jail videotape, showing him being dragged in and out of the Jail, could not be explained based on alcohol intoxication; rather, it had to involve hypothermia. However, he acknowledged that this conclusion reasoned backward, knowing Mr. Paul later died from hypothermia. He testified that, in Vancouver's moderate climate, hypothermia tends to occur slowly, so he felt it reasonable to say that Mr. Paul would have been hypothermic while at the Jail. Dr. Ferris acknowledged, however, that hypothermia may occur slowly or quickly, and nothing in an autopsy would give a precise answer as to when the person became hypothermic. He also recognized that there is no medically recognized timeline for hypothermia; each case is case-specific.[344]

f. The November 27, 2000 meeting

On November 27, 2000, Dr. Ferris presented his report at a meeting with Commissioner Morrison, Deputy Commissioner Matt Adie, Commission

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[342] Exhibit 183, pp. 4-5.
[343] Exhibit 183, p. 5.
[344] Transcript, Jan. 15, 2008, pp. 3–5, 10–20, 23–25; Exhibit 183 (also entered as Exhibit 155, Binder 1B, Tab 24).

Counsel Dana Urban, Q.C., and investigator Bill MacDonald.[345] Although the documentary record of what was said during this meeting is incomplete, several people who attended the meeting recalled Dr. Ferris making a statement to the effect that Frank Paul may have been dead before Cst. Instant placed him in the alleyway.

According to Mr. MacDonald, Dr. Ferris indicated that it was possible that Frank Paul died in the police wagon. Mr. MacDonald thought this was "more of an afterthought" remark, and he did not make a note of it.[346]

According to Mr. Urban, Dr. Ferris spontaneously said: "I can't even exclude the possibility that he was already dead when he was placed in that alley." The remark caught his attention and he noted it in some of his memoranda.[347]

According to Dr. Ferris, while he did not recall it and did not think he said it, he may have expressed that thought as a "throwaway" comment. It was not included in his opinion letter.[348]

g. Action taken after the November 27, 2000 meeting

Mr. Morrison testified that, in his view, Dr. Ferris's report was valuable, and he sent it to the Vancouver Police Board. He also sent it to Vancouver Regional Coroner Jeannine Robinson, asking that she consider calling an inquest. He then asked Mr. Urban to provide a written opinion on what his (Mr. Morrison's) next step should be.[349]

In Mr. Urban's December 16, 2000, legal opinion, he recommended that the Frank Paul matter be referred back to Crown Counsel to consider whether to lay criminal charges, and that Mr. Morrison defer his decision on a *Police Act* public hearing until after the Crown's decision.

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[345] Evidence of W. MacDonald, Transcript, Mar. 18, 2008, pp. 56–60; Evidence of D. Urban, Transcript, Apr. 2, 2008, pp. 23–25, 18; Evidence of D. Morrison, Transcript, Mar. 12, 2008, p. 207. Mr. Urban thought that Marilyn Whitfield may have been part of the meeting also.
[346] Transcript, Mar. 18, 2008, pp. 64–67.
[347] Transcript, Apr. 2, 2008, pp. 25–29.
[348] Transcript, Jan. 15, 2008, pp. 21–23, 63.
[349] Transcript, Mar. 12, 2008, pp. 53–55; Exhibit 152, Tabs 20, 21.

Mr. Urban testified about his recommendation:[350]

> I thought that even if Don changed—Mr. Morrison changed his mind and—that even if he changed his mind and decided he wanted a public hearing, that was unnecessary at the time until the Crown made that decision, because if the Crown decided to charge, there's your public forum, your search for the truth, your consequences, all those things that are in a different way looked at in Section 60(5). So if that played out, whether convicted or acquitted, many of those concerns under the *Police Act* would be answered and you have to look at matters at that point to see whether or not it's any longer in the public interest to proceed with a public hearing. There may have been no need for it.

Mr. Morrison agreed with this advice. On December 22, 2000, the matter was referred to Crown Counsel, along with Mr. Urban's opinion and Dr. Ferris's report.[351]

Also in December 2000, Mr. MacDonald went to the VPD and obtained the multiplex videotape of the Jail for December 5, 1998, when Frank Paul was dragged in and out of the Jail. He immediately took it to the RCMP's forensic lab, requesting that the lab develop a "slave tape" that would show, in isolation, the view of individual cameras from the Jail when Frank Paul was taken there. He received this tape on January 12, 2001. Mr. MacDonald was not aware of any audio recordings.[352]

h. Mr. Adie's recommendation to Mr. Morrison

In late April 2001, shortly before he resigned from the office of the PCC, Deputy Commissioner Adie wrote two memos to Mr. Morrison, recommending that he hold a public hearing. He stated that the file was extremely important, mentioning the *Police Act* criteria for a public hearing and his concern about criticism from the general public and outrage from the Native community. In one of the memos, he referred to

[350] Transcript, Apr. 2, 2008, p. 44.
[351] Exhibit 155, Binder 1B, Tab 29; Evidence of D. Urban, Transcript, Apr. 2, 2008, pp. 35–45, 49–50; Evidence of D. Morrison, Transcript, Mar. 12, 2008, pp. 55–57; Transcript, Mar. 13, 2008, pp. 66–69; Exhibit 155, Binder 1B, Tab 31; Evidence of M. Adie, Transcript, Apr. 4, 2008, pp. 73–75.
[352] Transcript, Mar. 18, 2008, pp. 62–64, 125.

the situation in Saskatchewan involving the treatment of Native people by Saskatoon police.[353]

i. The Crown's decision not to approve criminal charges

On August 15, 2001, Mr. Morrison received a one-page letter from Crown Counsel, informing him that no criminal charges would be approved. Mr. Morrison testified that he was disappointed both with the decision and with the absence of any explanation of why that decision was reached.[354]

j. The August 21, 2001 meeting

At an August 21, 2001 meeting, Mr. Morrison and OPCC staff discussed the Frank Paul matter, and the options open to PCC. Fortunately, then-Deputy Police Complaint Commissioner Barbara Murphy recorded these options,[355] which included holding a *Police Act* public hearing; asking the Attorney General to call a public inquiry; asking the Director of Police Services to order a special investigation or to conduct a policy review or study of the issues in the Paul case; and engaging in further OPCC research.

Mr. MacDonald testified that the meeting did not involve a review of the evidence or the video:[356]

> Essentially it came down to simply that the members had been disciplined and they accepted their discipline and that it was concluded that there would not be a public hearing because too much time had gone by and that was essentially it. It was a *fait accompli* at that point.

Mr. Morrison testified that, at that time, he had in mind several factors:[357]

- there had already been a significant delay, much of it owing to the Crown assessment;

[353] Exhibit 155, Binder 2, Tabs 15 and 16; Transcript, Apr. 4, 2008, pp. 80–89.
[354] Transcript, Mar. 12, 2008, p 59–60, 66; Exhibit 155, Binder 2B, Tab 18.
[355] Transcript, Mar. 17, 2008, pp. 7–10, 15–16, 3; Exhibit 155, Binder 2, Tab 22.
[356] Transcript, Mar. 18, 2008, p. 81.
[357] Transcript, Mar. 12, 2008, pp. 69–72; see also Evidence of B. Murphy, Transcript, Mar. 17, 2008, pp. 20–21.

- the Crown had now twice declined to approve criminal charges; and
- the officers had acknowledged responsibility and accepted their disciplinary sanctions; and the officers were not compellable as witnesses in a *Police Act* public hearing.

Mr. Morrison testified that he did not think a public hearing would achieve much. Although he considered the penalties inadequate, he did not expect a public hearing would lead to anything more than a somewhat longer suspension (the maximum suspension under the statute being five days, and the greater punishment of termination being unlikely, he felt). He testified:

> The problem with the public hearing mechanism is that it was dealing with two respondent officers, that's all. And I wasn't sure whether there wasn't some form of systemic problem. Clearly in the note to me from Matt Adie, he talked about the racial issue, but the fact is that you have an individual who, in my opinion, had been released from the control of the police when they were incapable of looking after themselves. One of the things that I was very interested in was to find out if that was a practice that occurred in other departments, both RCMP and municipal, in the province.[358]

Mr. Morrison went on to explain that a broader, systemic response, including one that could look at the RCMP's approach (a matter beyond his *Police Act* jurisdiction), would be preferable.

At the conclusion of this meeting, Commissioner Morrison decided not to order a public hearing under the *Police Act*.

k. Mr. Morrison's meeting with Chief Constable Blythe

Ten days later, on August 31, 2001, Mr. Morrison met, for lunch at a restaurant, with VPD Chief Constable Blythe and Insp. Rothwell. The record is not clear whether anyone else from Commissioner Morrison's office was present. At this meeting, Mr. Morrison advised Chief Constable

[358] Transcript, Mar. 12, 2008, pp. 72–76. For further discussion of the "province-wide" point, see Evidence of B. Murphy, Transcript, Mar. 17, 2008, pp. 28–29.

Blythe that he would not be holding a public hearing into the Paul matter.[359]

Mr. Morrison did not publicly announce this decision until January 18, 2002.[360] He testified that, while he ordinarily would make his decision public at this stage, he decided not to do so in this case because he was looking at other alternatives, and did not consider the file closed.[361]

l. Other alternatives that Mr. Morrison pursued

i. Request for an inquest

Mr. Morrison corresponded with, and on October 4, 2001, met with, Chief Coroner Smith, and asked him to consider calling an inquest.[362] He also wrote to the Solicitor General asking for an inquest, which would permit the respondent officers to be compelled to testify, and which could make broad recommendations to prevent similar deaths. It is apparent, from both the documentary record and Mr. Morrison's testimony, that he wanted to engage the coroner's process as a way of compelling the respondent officers to testify and be cross-examined.[363]

ii. Request for a province-wide review

On October 4, 2001, Mr. Morrison also petitioned the Solicitor General, by a separate letter, to undertake a province-wide review.[364] He outlined his idea of having Vince Cain (a former RCMP officer and former Chief Coroner) undertake a province-wide review, which could look at the RCMP as well as municipal forces, and which might look at the larger issue of the police practice of "breaching" people (under which, instead of arresting a person, an officer transports the person to a different part of the city and releases the person there).

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[359] Evidence of D. Morrison, Transcript, Mar. 13, 2008, pp. 82–83; Evidence of B. Murphy, Transcript, Mar. 18, 2008, pp. 6–7; Evidence of T. Blythe, Transcript, Feb. 27, 2008, pp. 23–24, 26, 91; Exhibit 110, Tab EE.
[360] Transcript, Mar. 12, 2008, pp. 84–86, 93–94; Exhibit 155, Binder 3A, Tab 3 (also at Exhibit 152, Tab 53).
[361] Transcript, Mar. 12, 2008, p. 85.
[362] As I noted earlier in this part, the Coroners Service had earlier decided to proceed by way of a Judgment of Inquiry, rather than an inquest.
[363] For example, see Transcript, Mar. 12, 2008, p. 156.
[364] Exhibit 155, Binder 3A, Tab 3.

Mr. Morrison testified that he was mindful of the cost associated with a public inquiry and wanted to suggest something cost-effective and responsive to the systemic concerns he identified. All these requests were declined.[365]

3. Commissioner Casson's handling of the Frank Paul complaint

After Mr. Morrison resigned in 2002, Benjamin Casson, Q.C., was appointed as PCC. He dealt with a few matters related to the Frank Paul case, including a request from the Paul family to have the Jail video provided to them, and a report from the VPD on the notification of Mr. Paul's next of kin.[366]

Mr. Casson considered the prospect of calling a public hearing in the Paul case. He obtained a legal opinion on his statutory authority to do so and, in reliance on that advice, concluded that the decision made earlier not to call a public hearing brought the authority under statute to an end, and he therefore lacked jurisdiction to effectively reverse the earlier decision made by Mr. Morrison.[367]

In the Fall of 2002, Mr. Casson also attempted to have Ted Hughes, Q.C. (a former justice and former Deputy Attorney General) review the Frank Paul file. He wanted a credible and independent person who would review the Paul file and provide a report of "what happened." This appointment was not made, because the parties could not agree on the terms of reference.[368]

4. Commissioner Ryneveld's handling of the Frank Paul complaint

Dirk Ryneveld, Q.C., became PCC on February 13, 2003. He reviewed the Frank Paul matter. He re-opened the OPCC file, ultimately publishing on January 16, 2004, written Reasons for Decision calling for a public inquiry into the death of Frank Paul.[369]

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[365] Transcript, Mar. 12, 2008, pp. 76–80, 86–93.
[366] Transcript, Mar. 19, 2008, pp. 193–95.
[367] Evidence of B. Murphy, Transcript, Mar. 17, 2008, pp. 57, 60–63, 78.
[368] Evidence of B. Casson, Transcript, Mar. 19, 2008, pp. 199–206; Evidence of B. Murphy, Transcript, Mar. 17, 2008, pp. 68–72, 74.
[369] Transcript, Mar. 13, 2008, pp. 137–40; Exhibit 155, Binder 5, Tab 1; Exhibit 184. Commissioner Ryneveld provided a copy of his Reasons for Decision, and a compendious binder of supporting documents, to the Attorney General, the VPD, the Coroners Service and the Solicitor General.

5. My conclusions about the response of the Police Complaint Commissioner

Based on this review of the evidence, I have reached several conclusions respecting the PCC's response to the death of Frank Paul. I heard during the evidentiary hearings considerable evidence about clashing personalities and a fractious atmosphere in the Office of the PCC during Mr. Morrison's tenure. I have chosen not to dwell on those matters in this report because, in my view, they do not assist me in determining what happened and why.

First, my ability to ascertain what happened in the OPCC (as well as what matters were discussed, what decisions were made at key meetings and what people were thinking) has been seriously hampered by the incomplete documentary record as it pertains to Mr. Morrison's tenure. The public is entitled to expect that, when a public body such as this deals with suspicious deaths and issues affecting professional careers and reputations, important milestones are recorded and preserved, to ensure thoroughness, fairness and transparency.

Second, while I do not think it would be appropriate for me to second-guess the substantive decision of Mr. Morrison, in September or October 2000, to obtain further information before deciding whether to order a public hearing, I am satisfied that the information that he had before him made such a decision reasonable.

Third, while I do not think it would be appropriate for me to second-guess the substantive decision of Mr. Morrison, in December 2000, to ask the Criminal Justice Branch to reconsider its decision not to approve criminal charges, I am satisfied that the information that he had before him made such a decision reasonable, in particular Mr. Urban's recommendation to do so. Referring the matter to the branch was a reasonable basis for postponing any decision about a public hearing; if the Crown approved charges, the events surrounding Mr. Paul's death would be canvassed during the criminal proceedings, which would obviate the need for a public hearing.

Fourth, I commend Mr. MacDonald for obtaining the Jail video showing Mr. Paul being dragged into and out of the Jail building. It portrayed the department's treatment of Mr. Paul, and his obvious incapacitation, in a way that galvanized

public attention and was, in my view, an important contributing factor to this inquiry being convened.

Fifth, I am satisfied that at the August 21, 2001 meeting, Mr. Morrison and OPCC staff fairly considered the options open to Mr. Morrison at that time. While Mr. Morrison testified that he would have applied the criteria set out in section 60(5) of the *Police Act*, the inadequate documentary record prevents me from knowing the extent to which he did so, or his reasoning in concluding that those criteria were not met. At this late stage, the most that I can say is that Mr. Morrison had a body of evidence before him from which one could reasonably conclude that the public interest did not compel a public hearing at that point in time.

Having said that, it was, in my view, a serious error of judgement for Mr. Morrison not to commit to paper this decision and the reasons for it, with particular reference to the statutory criteria in section 60(5). When a statute articulates the criteria so explicitly, it is reasonable to infer an underlying legislative intent to ensure principled decision-making and transparency. I say this especially in light of the careful case made out for a public hearing made by Bill MacDonald in his report. The commissioner had the clear authority to reject that advice but without a recorded and reasoned decision the public cannot be assured by written evidence that the proper principles were applied to the question. In my view, the public is entitled to expect that a public officer who is bound to apply such criteria will act in a manner that affirms those values.

Sixth, I question the appropriateness of the manner by which Mr. Morrison communicated his decision to the VPD (a lunch meeting at a restaurant), and I find his justification for a four-and-a-half month postponement in making his decision public (because he was pursuing other alternatives) unconvincing. It would have been, in my view, far more appropriate to communicate his decision to the department by letter, setting out the reasons for his decision. Similarly, nothing prevented him from promptly informing the public about his decision not to order a public hearing, and then seeking an inquest or a ministerial policy review.

I conclude my review of the public bodies' response to the death of Frank Paul with one general observation. During our policy roundtable discussions, counsel for one of the participants astutely observed that the single most important

document in these bodies' responses was the criminal investigation report prepared by Det. Staunton in May 1999:

- Professional standards investigation—Sgt. Boutin relied on it, with very little additional investigation, in his professional standards investigation, which led to the disciplinary measures being imposed.

- Coroners Service—Ms. Lister relied on information from the police in preparing her preliminary investigation report (which led to the decision not to hold an inquest), and Ms. Robinson relied heavily on it, in preparing her Judgment of Inquiry.

- PCC—Mr. MacDonald relied on the criminal investigation report (and the professional standards investigation report that was based largely on the criminal investigation report) in preparing his file review, and the report was central to the PCC's assessment, which led ultimately to Mr. Morrison's decision not to order a public hearing.

- Criminal Justice Branch—While I do not yet have a complete record of the branch's response to Mr. Paul's death, the evidence is clear that Det. Staunton's criminal investigation report became the Report to Crown Counsel, which would normally be the principal evidentiary source for deciding whether or not to approve criminal charges.

I conclude the quality of decision-making in these four subsequent "response" processes was largely dependent on the underlying criminal investigation report. Given the inadequacies I have already identified, the result was that the public was not well served by the reliance placed on it by the other response processes.

Further, I do not think that one can dismiss this as a single inadequately done investigation performed a decade ago. As I discussed earlier in this part, these inadequacies are largely attributable to the legislative regime for conducting criminal investigations in the case of police-related deaths—a scheme premised on the police investigating themselves. It is, in my view, a systemic flaw riddled with conflict of interest, which necessitates significant reform. I will explore this issue in more detail in Part 6.

PART 5—HOMELESS CHRONIC ALCOHOLICS

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Interim Report of the Davies Commission of Inquiry into the death of Frank Paul

A. How Our Society Deals with Chronic Alcoholics

1. The historical criminalization of public intoxication in Canada[370]

In the early 1800s drinking and drunkenness were part of pioneer life in Canada, and appear to have been woven into the social fabric of the time. In response, the temperance movement began in Canada in the 1820s, and would continue as an influential social movement over the next century.

One study suggests that in the second half of the 1800s, city and county jails were overflowing with drunkards, and there was some pressure to establish inebriate institutions or retreats for habitual drunkards. In most instances, due to a lack of political will or public funding, these institutions did not materialize. Some private institutions were established, but typically served clients who could pay for their treatment.

In the 1860s, local option laws appeared, which gave individual cities, municipalities and counties the authority to vote on whether they wanted to prohibit the sale of alcohol. In 1879 the *Canada Temperance Act* addressed the issue nationally.

Prohibition became more widespread during World War I. Many provinces implemented province-wide prohibition, and in 1917 national prohibition was imposed under the *War Measures Act*. By 1918 that Act was no longer in effect, and over the next few years most provinces developed a system of government control over alcohol sales and conditions of use. This legislation was the predecessor to our current liquor control laws, which typically include the offence of public intoxication.

The offence of public drunkenness has its roots in vagrancy laws, which sought to exert control over homeless, unemployed and unattached men. For example, in 1892 Canada's first *Criminal Code* defined vagrancy as including causing a disturbance in a public place by being drunk (s. 207).

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[370] The information in this section is drawn primarily from "Public Intoxication", a research paper presented during our policy roundtable discussions by Simon Fraser University criminology professor, Neil Boyd.

Until the 1970s, the authorities relied on the criminal law or on provincial regulatory legislation to control public intoxication. Drunks would be arrested, charged with an offence and brought to court, where they would typically receive short jail sentences, only to repeat the cycle many times.

2. Decriminalization in British Columbia

During the 1970s Canada and the United States began to treat public drunkenness as a public health concern requiring treatment and rehabilitation, rather than as a problem of criminal law requiring punishment. This shift was due to two factors—a change in public attitudes towards alcoholics, and the heavy burden that public drunkenness was placing on the criminal justice system. In some jurisdictions provincial laws were revised to allow the police to take people intoxicated in public to detoxification centres rather than to the police drunk tank. These centres were often affiliated with halfway houses, where alcoholics could be referred for treatment. The goal was to remove chronic alcoholics from the revolving door of the criminal justice system.

In British Columbia, the combined effect of two statutory provisions continues to make public intoxication a provincial offence:

- The *Liquor Control and Licensing Act*[371] states that a person who is intoxicated must not be or remain in a public place (s. 41(1)), and an officer may arrest, without warrant, a person found intoxicated in a public place (s. 41(2)).

- The *Offence Act*[372] states: "A person who contravenes an enactment by doing an act that it forbids, or omitting to do an act that it requires to be done, commits an offence against the enactment" (s. 5), which is punishable by a fine of not more than $2,000 or by imprisonment for not more than six months, or both (s. 14).

However, in the 1960s the province enacted amendments that had the effect of decriminalizing public intoxication. Section 91(1) of the *Offence Act* (as it now reads) provides that if a peace officer finds, in a place to which the public has access, a person who is in a state of intoxication, the peace officer may take that person into custody.

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[371] R.S.B.C. 1996, c. 267, available at http://www.qp.gov.bc.ca/statreg/stat/L/96267_01.htm.
[372] R.S.B.C. 1996, c. 338, available at http://www.qp.gov.bc.ca/statreg/stat/O/96338_01.htm#section5.

Once taken into custody, the peace officer has two options:

1. The person must be released:

   - on recovering sufficient capacity to remove himself or herself without danger to himself or herself or others, or causing a nuisance, or

   - if application is made sooner by an adult who appears to be capable of taking charge of the person, into the charge of the applicant (*Offence Act*, s. 91(3)).

2. If it appears to the peace officer that the person may be in need of remedial treatment because of the use of alcohol, the peace officer must, within 24 hours, take the person to a physician (s. 91(2)).

   - If the physician is satisfied that the person is in need of remedial treatment because of the excessive use of alcohol, then the physician may give a certificate to that effect, in which case the person may be taken to, examined, treated and detained in, an institution for the treatment and rehabilitation of chronic alcoholics, or to a *Mental Health Act* psychiatric unit or observation unit, for up to 72 hours.

     At the completion of that time period, the person must be released unless an application has been made for a confirming order (s. 91(4) and (6)).

   - An application for a confirming order may be made to a justice of the peace or to a Provincial Court judge. After hearing the evidence of the physician who has examined the person (and any other evidence of the person's addiction to, or use of, alcohol, and the evidence of the person), the justice may make an order that the person attend at or be detained in an institution where treatment is provided for chronic alcoholics, for an indeterminate term not exceeding 12 months, if satisfied that the person is in need of treatment and rehabilitation.

It is noteworthy that the decriminalization provisions of sections 91 and 92 of the *Offence Act* apply only to those portions of British Columbia and to those classes of persons that the Cabinet designates (s. 91(7)). During our policy roundtable discussions, counsel for the VPD tendered copies of Orders in Council indicating that between 1967 and 1974 designations were made under what is now s. 91(1). Although the wording of the Orders in Council is ambiguous, I understand that peace officers had been authorized to detain intoxicated persons until they had

recovered sufficient capacity to remove themselves, without endangering themselves or others, or without causing a nuisance, within the following designations:

- 1967 Kamloops and Vancouver[373]
- 1969 Prince George[374]
- 1970 all females within the province[375]
- 1972 Prince Rupert[376]
- 1974 all males within Vancouver, Prince George and Kamloops[377]

Two of these Orders in Council[378] also designated the fourth floor of the Jail and 424 West 3rd Avenue, Prince Rupert, as institutions for the treatment and rehabilitation of chronic alcoholics. As I indicated earlier, section 92 of the *Offence Act* authorized a justice to order a chronic alcoholic to be detained for up to 12 months in an institution where treatment was provided for chronic alcoholics, if satisfied that the person was in need of treatment and rehabilitation. These two designations appear to have been in furtherance of that power. It is not clear whether confirming orders were ever made in these two municipalities and, if they were, whether these jail premises were converted into detox and treatment facilities with appropriate medical and counselling services.

Whatever the historical significance of the remedial treatment provisions of sections 91 and 92 of the *Offence Act*, it is my understanding that the VPD does not apply them in practice today. The department relies exclusively on s. 91(1), which authorizes a peace officer to take into custody people who are in a state of intoxication in a public place, and to release them when they have recovered sufficient capacity to remove themselves without endangering themselves or others, or without causing a nuisance.

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373 Order in Council 583, approved and ordered on February 21, 1967.
374 Order in Council 1830, approved and ordered on June 3, 1969.
375 Order in Council 1615, approved and ordered on May 7, 1970.
376 Order in Council 1354, approved and ordered on April 6, 1972.
377 Order in Council 4143, approved and ordered on December 23, 1974.
378 Order in Council 1766, approved and ordered on May 31, 1969, and Order in Council 1354, approved and ordered on April 6, 1972.

3. The current practice in Vancouver for dealing with public intoxication

a. Crisis intervention

Paragraph (g) of this inquiry's Terms of Reference invites me to put myself in the place of a police officer who comes across a person who is incapacitated by alcohol or drug use, who does not need to be detained but who requires immediate health care or social services because of the person's incapacitation.

A Vancouver police officer's response is governed by the department's *Regulations and Procedures Manual* (Manual), section 2.04 (Arrest – Hold State of Intoxication in a Public Place (H/SIPP)).[379] It calls for the officer to make a series of sequential decisions:

i. Is an ambulance required?

There are two situations in which an ambulance must be called—if an intoxicated person is:

- "unconscious or unresponsive—(Clause 12)," or
- "medically questionable, injured, ill or requires the use of painful stimuli to elicit a response—(Clause 2)."

ii. Should the person be arrested?

For example, arrest would be appropriate if the person is committing a criminal offence, or if there is an outstanding warrant for his or her arrest.

iii. Should the person be detained for being in a state of intoxication in a public place?

If the person does not need to be arrested for a criminal offence, section 91(1) of the *Offence Act* authorizes a police officer to take a person into custody if that person (1) is intoxicated and (2) is in a place to which the public has access. Although "intoxication" is not defined, section 91(3) might provide some assistance. It states that a person who has been taken into custody for being in a state of intoxication may be released on recovering sufficient capacity to remove himself or herself without endangering himself or herself

[379] Some sections of the VPD's *Regulations and Procedures Manual* are available at http://vancouver.ca/police/Planning/RPM/RPM.pdf.

or others, or without causing a nuisance. If a person can be released when he or she has recovered capacity, this implies that the person did not have such capacity at the time of arrest. If the officer decides not to detain the person, the officer may allow the person to go on their way, or may call on the police wagon or Saferide to take the person home.

iv. Where should the person be detained?

If the officer decides to arrest the person under s. 91(1), then the officer has two options on how to proceed:

- Delivery to the Detox Centre's sobering unit: This is a small short-term facility operated by Vancouver Coastal Health, where intoxicated people are cared for and monitored for a few hours, until they are capable of managing on their own. According to Clause 10(a) of the VPD Manual, Detox Centre staff may refuse to admit an intoxicated person if that person has been judged as unsuitable for admission due to a history of violent behaviour at the Detox Centre, or that person makes threats or displays behaviour indicating the potential for violence.
- Delivery to the Jail: If the person is not eligible for admission to the sobering unit, the person must be delivered to the Jail, which includes a separate holding facility for intoxicated people.

v. How should the person be transported?

If the officer decides that the person should go to the sobering unit, the officer may request transport from Saferide or, if it is not available, from the police wagon. Saferide is a free, safe transportation service provided for clients with alcohol and drug problems, run by the non-profit Vancouver Recovery Club. It makes about 15,000 pickups a year, of which approximately half are to assist chronic alcoholics such as Frank Paul.

Since the VPD resumed responsibility for operating the Jail in 2006,[380] a new *Manual of Operations* has been implemented, although it awaits final review and sign-off by the department's executive. Some of the relevant provisions of that *Manual of Operations* applicable to intoxicated prisoners are:

[380] The Jail had been operated by the BC Corrections Branch between 1999 and 2006.

- Whenever any prisoner enters the Jail with wet clothing, the Jail staff shall ensure that the prisoner is given a change of clothes, or appropriate clothes, to prevent the onset of hypothermia or other illness.
- The nursing staff must visually assess intoxicated prisoners when they are admitted to the Jail, and conduct a more thorough examination if required.
- The nursing staff must assess intoxicated prisoners every hour.
- If it appears that an intoxicated prisoner is at risk of aspiration, the nursing staff must place the prisoner into the recovery position.
- For intoxicated prisoners who remain in custody for more than four hours, the nursing staff must awaken the prisoner every hour, to get a verbal response and ensure that the prisoner's condition is not deteriorating.
- The Jail guard must physically check and assess intoxicated prisoners every 15 minutes, and move them into the recovery position if they are sleeping.
- Prior to a prisoner (especially an intoxicated prisoner) being released from the Jail, the Jail staff must ensure that the prisoner is able to care for himself or herself, is dressed appropriately for the weather and has a place to go and/or a way to get to their residence.
- Consideration must be given to the time of day a person is being released, as well as any vulnerability the person may have due to gender, age, mental state, suitability of clothing, weather, lack of money (i.e., for transit/taxi), or any other relevant factor.
- Prior to release, the prisoner should be asked if she or he has a place to go and the means to get there. If appropriate, they should be offered bus tickets, Saferide, or a phone call to a friend/family member to pick them up, particularly in inclement weather.

b. Detox and treatment programs

I was advised that there are various detox and treatment programs and facilities in Vancouver for alcoholics, but they are not available to people who are in a state of intoxication. In other words, when a police officer comes upon a person in a public place who is incapacitated due to intoxication from alcohol or drug use, the only options open to the officer are a hospital's emergency ward, the Detox Centre's sobering unit, or the

Jail. It is my understanding that this situation has not changed since Frank Paul was taken into custody on December 5, 1998.

c. Programs and services for homeless chronic alcoholic Aboriginals

In order to gain an appreciation of the programs and facilities that are currently available for chronic alcoholic Aboriginals, the inquiry retained Vancouver lawyer Ardith Walkem, a member of the Nlaka'pamux Nation, to:

- identify the health care and social services programs and facilities that are currently available in the city of Vancouver, that have been developed specifically for Aboriginal men and women who are incapacitated by alcohol or drug use, and
- consult with the Aboriginal community in the Downtown Eastside, to determine what additional health care and social services programs and facilities they think are necessary, in order to address the needs of Aboriginal men and women who are incapacitated by alcohol or drug use.

In Ms. Walkem's research paper (see Appendix L), she summarized the mandates of, and programs offered by, 14 Aboriginal organizations in Vancouver's Downtown Eastside, which work with Aboriginal chronic alcoholics, including those with mental health and homelessness issues.

The services provided by these organizations include a walk-in medical and dental clinic, mental health and addictions counselling, drug and alcohol treatment referrals, political advocacy, residential facilities for Aboriginal men recently released from federal penitentiaries, emergency shelters and transitional housing for homeless Aboriginal women, or simply a temporary safe haven and emotional support for those living on the streets.

Notwithstanding this impressive spectrum of services, Ms. Walkem began her paper with the blunt assertion that:

There are no Aboriginal organizations in the Downtown Eastside equipped to provide comprehensive services to chronic alcoholics in a similar position to Frank Paul.[381]

This finding mirrors what the inquiry has learned from other sources about homeless chronic alcoholics generally—inadequate sobering, detox and housing facilities and programs. Having said that, Ms. Walkem's research offers some reason for optimism:

- The Native Courtworker and Counselling Association of British Columbia is currently developing a residential treatment facility in the Downtown Eastside for Aboriginal people suffering from chronic alcoholism and addictions, which may include:
  - ten "flop" beds for the winter months, which would be available to Aboriginal people even if they were intoxicated, and provide a safe place for them to stay for a short time, and
  - this proposed facility would operate according to a harm reduction model, similar to a sobering centre. The facility would meet the critical needs of Aboriginal homeless chronic alcoholics, but would only be able to meet a small portion of the existing need.[382]

- The Western Aboriginal Harm Reduction Society advocates for the development of culturally appropriate harm reduction programs and services, including:
  - the development of an alcohol maintenance program to wean members off alcohol or solvents, access to detox and treatment services, and the creation of a 24-hour, barrier-free Aboriginal drop-in centre in the Downtown Eastside where members can take Aboriginal people they find incapacitated on the streets.[383]

Ms. Walkem also makes a persuasive case for the development of culturally appropriate facilities and programs for chronic alcoholic Aboriginals, for several reasons. First, Aboriginals may constitute up to 40 percent of Vancouver's chronic alcoholics.[384] Second, the underlying causes for Aboriginal addiction arise from unique historical and social circumstances, including cultural loss and disconnection as a result of

[381] Appendix L, p. 405.
[382] Ibid., p. 413.
[383] Ibid., p. 420.
[384] This percentage is consistent with former Insp. Frail's testimony (which I will discuss in the next section), that in 1996 approximately 45 percent of those detained by the VPD for public inebriation were Aboriginal men.

moving from reserves to the Downtown Eastside, the impacts of the Indian residential school system, and the impacts of provincial child welfare systems. Third, most non-Aboriginal facilities do not offer the cultural safety many Aboriginal people need in order to confront and deal with the many complex issues they experience.

While some of the recommendations included in Ms. Walkem's research paper (based on her consultations with the Aboriginal community in the Downtown Eastside) go beyond the mandate of this inquiry, I am impressed with the common ground between the Aboriginal community's perception of what needs to be done and my own thinking on how best to assist homeless chronic alcoholics, so many of whom are Aboriginal. For example, I share the Aboriginal community's concern for what is needed:

- a nonjudgmental and safe environment that accepts that, while some people will not choose to give up drugs and alcohol, and others who try to be abstinent may falter, it does not give up on them,[385]
- an Aboriginal Housing First strategy, including a 24-hour, barrier-free, entry-level shelter facility for Aboriginal chronic alcoholics, that operates according to a harm reduction strategy (which would include a sobering centre, and might also include controlled access to alcohol),[386]
- sufficient outreach workers in the Downtown Eastside to find and assist Aboriginal people in need of such a facility,[387] and
- the services provided to chronic alcoholic Aboriginals must also include services for those with concurrent mental health issues.[388]

I will discuss these issues in more detail later in this part.

d. Recent attempts at reform

i. Removing rice wine from grocery stores

The VPD has attempted for many years to combat public inebriation. Former Insp. Frail testified[389] that in 1996, when he

[385] Appendix L, p. 434.
[386] Ibid., pp. 435–438.
[387] Ibid., p. 437.
[388] Ibid., p. 438.
[389] Transcript, Jan. 29, 2008, pp. 121–159.

transferred back to the Downtown Eastside, he discovered that police, fire and ambulance units responded to approximately 4,000 "man down" calls annually, almost all of which were cases of public inebriation. Often the fire department or ambulance crews would have to wait up to 45 minutes for the police wagon to arrive.[390] In about half the cases, the inebriated person was capable of moving along on his or her own, sometimes with the assistance of a friend. The other half would be transported to the Detox Centre's sobering unit or, if there was a concern about violence, to the VPD's Jail.

Insp. Frail's discussions with Saferide revealed that approximately 45 percent of these public inebriates were Aboriginal men, and about 90 percent of them were intoxicated on rice wine.

At that time, rice wine was sold in 17 grocery stores in the Downtown Eastside. It was not controlled by the liquor control and licensing branch because, with two percent salt content, it was not considered palatable liquor. However, it had 38 percent alcohol (and cost much less than palatable wine), which made it very attractive to chronic alcoholics, who would dilute it with water to reduce the effect of the salt.

Insp. Frail recounted a two-year campaign that led, in December 1999, to the provincial government ordering that the sale of distilled rice alcohol be restricted to government liquor stores.

ii. Proposal for a sobering centre

In July 1995, the City of Vancouver and the Province of British Columbia agreed that, by March 1999, the BC Corrections Branch would take over, from the VPD, responsibility for the Jail, which included the Jail's "drunk tank." However, it was a term of this contractual arrangement that people briefly detained for being intoxicated in a public place, but not charged criminally, would not

[390] Insp. Frail estimated that in 1996 it cost the VPD nearly $800 to attend a call and write up a report, and it cost the ambulance service between $450 and $550 to attend a call: Transcript, Jan. 29, 2008, pp. 177–178.

be allowed in the new Jail. The rationale for this term was that the Corrections Branch only dealt with people charged or convicted of criminal offences.

This meant that the parties had only a limited time to devise a different strategy for the handling of chronic alcoholics. There was a recognition that public intoxication and detoxification were health issues, and that the Downtown Eastside of Vancouver was in desperate need of a sobering centre, a safe place to hold people intoxicated by drugs or alcohol.

By late 1997, a proposal emerged that would eventually see three floors of the old Jail, situated at 324 Main Street, converted into a state-of-the-art sobering facility capable of housing up to 40 individuals in a six-hour to three-day triage setting. It would house males, females and youth intoxicated by drugs or alcohol, and mentally disordered offenders. Until such a facility could be developed, it was proposed that the fourth floor of that building be renovated, for use as an interim sobering facility.

By early 1998, the City of Vancouver (including the VPD), the Vancouver/Richmond Health Board and the Ministry for Children and Families began negotiations, and a VPD inspector was appointed project manager. A steering committee retained a consultant, who in June 1998 developed a detailed *Acute Intoxication Intervention Service Plan*, calling for a two-phase response:

(1) Phase 1 would be a short-stay (7–12 hours) safe haven for those acutely intoxicated by alcohol or drugs. It would be capable of handling up to 50 individuals, who would come in on their own; be brought in by the police, friends or Saferide; or be referred by other agencies. It would include a secure area for those posing a serious threat of violence. It would have the capacity to hold people involuntarily until they were capable of making rational decisions.

(2) Phase 2 would be a voluntary 72-hour non-medical detoxification program in the same building housing the Phase 1 sobering centre, with 16–20 beds. It would bridge

> the gap between the sobering centre and more structured programs of the addiction treatment system of care.

By July 1998, some parties were questioning the suitability of (and cost of renovating) the old Jail facility. The other options under consideration were:

- the Coroner's Court building at 236 East Cordova Street,
- to search for an alternate site (which might include construction of a purpose-built facility), or
- to convert an existing hotel, which would include a sobering centre, a detox facility, alcohol- and drug-free housing and an alcohol and drug intervention service.

By late 1998, serious disagreements over responsibility for chronic alcoholics, and differing funding priorities, emerged. This resulted in the VPD exercising its rights under the 1995 *Project 222/ Vancouver Jail Agreement*, to require the Corrections Branch to accept chronic alcoholics:

> Intoxicated persons or mentally disordered persons who are not charged with a criminal offence will not be admitted to the Jail unless there is, in the VPD's opinion, an immediate and serious risk posed to the safety of the person or to the public at large.

By June 1999, the Vancouver/Richmond Health Board had modified the consultant's proposal. The proposed new facility (at 324 Main Street) would include:

- a 40-mat sobering centre with eight single, safe rooms. This would include 18 mats from the existing Detox Centre's sobering unit, plus 22 new mats, and
- a 40-bed voluntary detox centre for short-stay (72 hours) and medium-stay (up to seven days). This would include 24 beds from the existing Detox Centre plus 16 new beds.

Although discussions continued for several more years, no agreement was reached respecting development of a new sobering/detox centre. Consequently, the scheme that was in place

when Frank Paul was arrested in December 1998 remains in place today.

B. This Inquiry's Terms of Reference

Paragraph (g) of the Terms of Reference instructs me:

> To identify the health care and social services programs and facilities available in the City of Vancouver that the police may access if a municipal constable determines that a person should not be detained but the person requires immediate health care or social services because the person is incapacitated by alcohol or drug use.

I have been asked to prepare an inventory of current services that an officer responding to a "man down" call can draw on. As I noted earlier in this report, that list is very short—the emergency ward of a hospital, the short-term sobering unit attached to the Detox Centre, or the Jail. Police officers are already aware of these limited options, and merely reciting them in this report would neither assist them nor offer guidance to our political leaders and policy makers.

It has become clear during this inquiry that how our society deals with homeless chronic alcoholics is inadequate. While I commend the compassion with which many individual police officers, ambulance attendants and emergency ward staff treat such people, the reality is that these current services amount to little more than revolving doors.

Intoxicated people are taken into custody until they sober up, and are then put back on the street with little or no attention given to their homelessness, their addiction or, in many cases, their mental illness. As Frank Paul's experience shows, the vicious cycle repeats itself with alarming regularity (and at enormous cost to the public), and the health and safety of homeless chronic alcoholics are needlessly put at risk.

It seems that despite the fact that those who respond to "man down" calls discharge their roles competently and professionally, no one steps back from the immediate encounter to look at the broader picture and draws the obvious conclusion: "This is not working."

Now that this inquiry has shone a spotlight on the problem, a choice must be made. We either perpetuate the current revolving door response to public intoxication, or we break the cycle and develop a new approach. I cannot, in good conscience, do the former. It seems that everyone working in this system knows that our current approach is not

working, and is harmful and expensive, and that there are other approaches that have had much better outcomes. We can and should do more.

I turn now to a brief discussion of my understanding of this issue, of innovative programs in other jurisdictions, and my suggestions for how the crisis facing homeless chronic alcoholics in Vancouver might be addressed.

C. Assisting Homeless Chronic Alcoholics

1. The macro problem—homelessness, addiction and mental illness

We are all acutely aware of the homelessness epidemic that has swept through many of British Columbia's municipalities over the past decade. Those who study this issue soon realize that there is more to homelessness than not having a home. It is inextricably intertwined with addiction and mental illness. Several recent studies in British Columbia have attempted to quantify the extent of homelessness, and social costs associated with homelessness.

a. The Victoria Mayor's Task Force

In May 2007, the mayor of Victoria, BC, struck the Task Force on Breaking the Cycle of Homelessness, Addictions and Mental Health. A Homeless Needs Survey conducted for the task force identified 1,242 homeless or unstably housed individuals in the Capital Regional District, and painted a disturbing picture of the interrelationship between homelessness, mental illness and addiction:

- 30 percent of the homeless are high risk for health needs,
- 40 percent of the homeless suffer from diagnosable mental illness,
- 50 percent of the homeless are struggling with problematic substance abuse including alcohol, drugs that are injected (most commonly heroin and cocaine), and drugs that are smoked (including crack cocaine and crystal methamphetamines),
- at least 40 percent of Victoria's 1,500–2,000 injection drug users are homeless or unstably housed,
- 74 percent of the homeless are infected with the hepatitis C virus, and 13 percent are infected with HIV,

- 25 percent of the homeless have co-occurring disorders (mental illness and substance abuse problems), and
- Aboriginals, who account for about 3 percent of the area's population, account for 20–25 percent of the homeless population.

In its October 19, 2007 report,[391] the task force found that, while Victoria residents have access to top-tier health and care services, it does not appear that the core needs of homeless residents are being met. The problems include the inappropriate use of services, the revolving door syndrome noted earlier, varying quality of care and lack of integration of services. It concluded that:

> Difficulties facing homeless residents are multiple, complex and irrevocably intertwined, and a system that does not provide comprehensive, integrated and coordinated services will not be successful in breaking the cycle of homelessness.[392]

The expert panel undertook a review of the best practices literature. It concluded that a paradigm shift is needed—a different way of thinking about the services needed, in order to effectively deal with homelessness, mental illness and addictions. In its view, several best practices are essential, including a client-centred approach, low-barrier programs that do not require clients to be abstinent or in treatment for mental illness, and an emphasis on harm reduction such as needle exchange services, substitution therapy and safe consumption sites.

According to the expert panel's analysis, other jurisdictions have found that there are two key components of a successful response to homelessness, mental illness and addictions:

- Housing: Current public housing initiatives often follow a continuum of care that expects participants to become more engaged in abstinence and treatment as they progress to more intense or client-specific services. This approach has been criticized for being too stressful for clients, lacking in choice, and making housing dependent on the client accepting treatment. A

[391] See Mayor's Task Force on Breaking the Cycle of Mental Illness, Addictions and Homelessness: http://www.victoria.ca/cityhall/tskfrc_brcycl.shtml.
[392] Expert Panel's Report, pp. 8–9.

shift in thinking and practice is taking place among service providers who work with these vulnerable populations: the recognition that effective treatment for homeless residents with mental illness and substance abuse problems requires stable, supported housing—and these must come first, before other services are offered. Put another way, housing is a place to live, not to receive treatment. Housing is necessary during, following and regardless of treatment.

- Assertive community treatment: These services are provided by a community-based, multidisciplinary team that provides support, treatment and rehabilitation services to clients where they live and work, rather than in an agency setting. The team consists of professionals with backgrounds in social work, substance abuse treatment, counselling, vocational rehabilitation, nursing and psychiatry. This model emphasizes outreach, frequent contact with clients, relationship building and individualized services. Staff-to-client ratios are kept low (e.g., 10:1), and the team is on call 24 hours a day to support clients through crises and emergencies. The types of services provided would include assistance in finding and keeping a home, supportive counselling and psychotherapy, substance abuse services, interpersonal and life skills development, assistance in accessing entitlements (e.g., social assistance), and crisis response.

According to the expert panel, research into the Assertive Community Treatment model has demonstrated improved housing stability, fewer hospitalizations, better retention in mental health services and higher patient satisfaction. The panel referred to New York City's Pathway Program. In a five-year study, almost 90 percent of the Pathway's clients taken off New York streets were still housed at the end of the study period, compared to less than half of those who had been housed through more traditional methods.

b. The Simon Fraser University study

BC's Ministry of Health commissioned the Centre for Applied Research in Mental Health and Addiction in the Faculty of Health Sciences, Simon Fraser University, to provide up-to-date information respecting the scope of the homelessness, addiction and mental illness problem, with recommended solutions and associated costs.

In its February 2008 report, entitled *Housing and Support for Adults with Severe Addictions and/or Mental Illness in British Columbia*,[393] the authors draw our attention to the numbers of individuals concerned and the associated costs of remedial action:

- Approximately 130,000 adults in BC meet the criteria for severe addictions and/or mental illness.
- Approximately 39,000 adults in BC with severe addictions and/or mental illness are inadequately housed, of which 11,750 are absolutely homeless.
- The average street homeless adult in BC with severe addictions and/or mental illness costs the public system in excess of $55,000 per year.
- Provision of adequate housing and supports is estimated to reduce this cost to $37,000 per year.[394]

The authors recommended several key actions, including the following:

- Housing first: This would provide permanent, independent housing to people without time limits or requirements for engagement in treatment.
- Multidisciplinary treatment teams: Fully integrated, multidisciplinary Assertive Community Teams to reach the "hardest to house" and similar models of intensive case management, with fidelity to low caseloads, have been shown to reduce in-patient hospitalization, decrease substance use and symptoms of mental illness, and increase community tenure for people who are homeless.
- Low-barrier housing: Approximately 15 percent of homeless people with severe substance use are unable to maintain independent housing, and would benefit from a low-barrier housing model.
- Harm reduction: Facilities that accept the use of drugs and alcohol on-site should be readily available to address the needs of homeless people with severe addictions.
- Discharge policies and practices: Hospitals and correctional institutions should establish and implement discharge protocols for people with no fixed address. No one should be discharged

[393] See http://www.carmha.ca/publications/index.cfm?contentID=29.
[394] This is, in my view, a significant finding—it may cost about one-third less to replace today's "revolving door" approach with a comprehensive set of facilities and services for homeless chronic alcoholics.

> from an institution directly to the street or a shelter without prior arrangement and follow-up.

The authors concluded by stating:

> Excluding capital costs, the cost of providing supported housing and other health services to this population of adults with SAMI [severe addictions and/or mental illness] is lower than the cost incurred through use of emergency departments, the corrections system, and emergency shelters when they are homeless. Without adequate housing and support, people with SAMI who are homeless often cycle through the streets, prisons and jails, and high-cost health care settings such as emergency rooms and psychiatric inpatient units. This is ineffective and costly in both human and financial terms.
>
> Furthermore, research has shown that people with SAMI who are homeless, once believed to be unreachable and difficult-to-serve, can be engaged in services, can accept and benefit from mental health and substance use services, and can remain in stable housing with appropriate supports. It is time to implement these evidence-based solutions for British Columbians in need.[395]

2. The micro problem—homeless chronic alcoholics

In March 2008, the Greater Vancouver Regional Steering Committee on Homelessness conducted a count of the homeless. Within the region as a whole, it enumerated 2,592 homeless persons, an increase of 19 percent since 2005. Within the city of Vancouver, the number of homeless was 1,547.[396] Those conducting the survey acknowledged that the homeless count process is an undercount, and the actual number of homeless is greater.

While the incidence and growth of homelessness poses a profound challenge for municipalities and the provincial government, the homeless chronic alcoholic cohort is much smaller. They are predominantly men, frequently middle-aged, with a longstanding addiction to alcohol and associated medical and mental illnesses. When consumable alcohol is not available, they often resort to rice wine or mouthwash. There appears to be little crossover between this group and intravenous drug users. One of the consequences is that they are not nearly as involved in street crime and residential break-ins, but are more frequently

[395] See http://www.carmha.ca/publications/index.cfm?contentID=29, p. 14.
[396] See http://www.intraspec.ca/2008HomelessCountPreliminaryFS-April.pdf.

characterized as "nuisances." It is my understanding that Frank Paul was representative of this group.

No one knows for sure how many homeless chronic alcoholics there are in Vancouver. Those with whom the inquiry has consulted have suggested as few as 50, or as many as several hundred. Whatever the exact number, they appear to be a reasonably identifiable group, with predictable patterns of behaviour and unique needs.

The interrelatedness of homelessness, alcohol addiction, and mental illness is a dynamic and rapidly changing area of policy development in which I claim no special expertise. I have, however, been introduced to innovative programs in several other jurisdictions that have experienced better outcomes, and before offering my suggestions for what assistance might be provided to homeless chronic alcoholics in Vancouver, I provide here a brief summary of those programs.

3. Homeless chronic alcoholics—the experience in other jurisdictions

Many European and North American jurisdictions have developed impressive new approaches to dealing with public inebriation. I will comment briefly on three that I am familiar with—two Canadian and one American—that illustrate how to address the underlying needs of homeless chronic alcoholics.

a. Ottawa

The Shepherds of Good Hope charity offers a managed alcohol program, which it describes as follows:

> The Managed Alcohol Program (MAP) serves 23 men and women who are extremely high medical risks when living on the streets. Its intent is to reduce harm to the individual and to the community at large by preventing binge drinking and the consumption of alternative sources of alcohol, such as mouthwash. MAP also strives to reduce injuries, the use of crisis services and incidents of community disruption. Our program provides a controlled access to alcohol (5 oz per hour from 7:30 a.m. to 9:30 p.m. based on assessments), ongoing health assessments and monitoring, access to counselling, social and clinical services, as well as food and permanent housing. The Managed

> Alcohol Program has a key partnership with the Inner City Health Project.[397]

This Managed Alcohol Program grew out of a multi-year study conducted by researchers at the University of Ottawa and the Ottawa Hospital.[398] The study tracked a small group of chronic alcoholics (15 men and two women) who had been homeless for at least two years. They had an average age of 51 years, had alcoholic parents, had started drinking in their early teens and were not educated beyond high school. They had been alcoholics for an average of 35 years, with most consuming non-beverage alcohol. They consumed, on average, 46 drinks per day, and most had tried detox and abstention but were unable to maintain sobriety.

During the two-year study, the participants were provided with housing and meals. They were given up to a maximum of five ounces (140 mL) of wine or three ounces (90 mL) of sherry hourly, on demand, from 7:00 a.m. to 10:00 p.m., seven days a week. Nurses and two physicians associated with the project provided medical care 24 hours per day.

The researchers found that:

- The amount of alcohol consumed decreased from an average of 46 drinks per day to eight drinks.
- The number of emergency department visits per participant per month dropped by 36 percent (from 0.79 to 0.51).
- The number of police encounters per participant per month dropped by 51 percent (from 1.07 to 0.52).
- Most participants reported improved sleep, hygiene, nutrition and health.

The authors concluded, at p. 48:

> For people whose drinking pattern has stabilized in MAP [the managed alcohol program], psychiatric evaluations and follow-up have been successful. Finally, the option to detoxify from alcohol is always presented; once stabilized in the program, a few participants have successfully been medically detoxified and received housing, a

[397] See http://shepherdsofgoodhope.com/programs.html.
[398] *Canadian Medical Association Journal*, Jan. 3, 2006, 174(1), pp. 45–49. See http://www.cmaj.ca/cgi/reprint/174/1/45.

> formidable accomplishment considering the severity of an on-average 35-year addiction in which subjects drank daily to unconsciousness. This appears attributable to tempering alcohol consumption in a safe environment, which makes alterations in behaviour, including detoxification, possible.... Part of the success of MAP has likely been due to the supportive housing provided, but housing alone would not have prevented alcohol-seeking, consumption and the harm therefrom.

Before turning to the program in Toronto, I will refer briefly to the testimony of Senator Larry Campbell,[399] who served as BC's chief coroner between 1996 and 2000 (and subsequently as mayor of the City of Vancouver, in which capacity he acted as chair of the Vancouver Police Board). He spoke in favour of Ottawa's managed alcohol program, for several reasons—it results in the consumption of safer palatable alcohol, it reduces the amount consumed, it improves health and it eliminates the need to engage in criminal activity in order to raise funds to purchase alcohol. In his view a managed alcohol program significantly reduces police and other public health and other social services costs—the savings could be four to ten times the cost of administering a managed alcohol program.

b. Toronto

The City of Toronto's Shelter, Support and Housing Administration offers a wide range of shelter and affordable housing options. It provides approximately 3,000 shelter spaces for single adult men, women and youths, approximately 950 shelter spaces for families and 930 spaces for those with a psychiatric condition (in 52 boarding homes and rooming houses).

Following the death of three homeless men in the mid-1990s, the Annex Harm Reduction program at Seaton House was developed. It recognized that a strict abstinence approach often did not work—chronic alcoholics who had to choose between drinking on the street, or living in a shelter, would often choose drinking on the street.

[399] Transcript, Jan. 25, 2008, pp. 58–62.

The Annex program now provides 149 beds for single adults and youth. When it began, it developed a bottle exchange program. Clients who were drinking non-palatable alcohol (such as mouthwash, cooking wine or rubbing alcohol) could exchange it for a safer wine replacement. A managed alcohol program was introduced in 1997. In 2000, the Annex opened an infirmary in association with St. Michael's Hospital, which provides on-site medical care, physician education and palliative care.

c. Portland, Oregon

In the early 1970s, Portland's Old Town/Chinatown neighbourhood was populated largely by older men living in shabby, crime-ridden single room occupancy (SRO) buildings. The rent was cheap, the drug of choice was alcohol and Portland's inebriate problem was one of the worst in the nation.

In response to this growing problem, the City of Portland and Multnomah County created, in 1979, a non-profit organization (now known as Central City Concern) to administer a federal public inebriate grant.

Central City Concern initially focused on alcohol recovery treatment and affordable housing. It soon learned that safe housing was of paramount concern to those in recovery. It began acquiring urban SRO hotels and rooming houses, and renovating them. In the 1980s, it extended its recovery programs to those addicted to crack cocaine and heroin. It provided alcohol- and drug-free housing to support those in recovery and their families. In the 1990s, it added employment training and work opportunity programs. In 2001, it added mental health programs and primary health care for the homeless.

Central City Concern has a staff of 460, and an annual operating budget of $28 million. It manages 1,400 living units, and serves an estimated 15,000 individuals annually.

One of the crucial aspects on the Portland program is that it is civilian-based. The Portland Police Department does not arrest people for being intoxicated in a public place, and the police station does not have a drunk tank. If a police officer responds to a "man down" call, the officer will

either deliver the person to Central City Concern's sobering station, or call the station for pickup. Indeed, if a police officer arrests an intoxicated person for a criminal offence, the officer will take the person to the Jail for booking, release the person on bail and then transfer the person to the sobering station until they are capable of managing on their own.

The entry point for many of Central City Concern's clients is its Hooper Center Sobering Station, located in downtown Portland.[400] It accepts people who are intoxicated by alcohol or incapacitated by drugs, for short stays (three to six hours), until they are capable of managing on their own. About 75 percent of those admitted are brought by the police. The Hooper Center also operates its own van program, in which a driver and an emergency medical technician roam Portland's streets 16 hours a day. When they find an inebriated person, the technician does a medical assessment and, where appropriate, calls an ambulance or transports the person to the sobering station. The van staff is deputized under Oregon's civil hold rules to deliver intoxicated people to care.

The Hooper Center has approximately 12,000 admissions per year. It has a supervising medical director and is staffed by trained emergency medical technicians (not nurses). There are three large sobering rooms, and four single-person "safe" rooms.

The second floor of the Hooper Center is a 54-bed subacute detoxification unit. It is a voluntary program for those wanting to safely withdraw from alcohol or drug use and to begin the recovery process. Detoxification usually takes between four and 10 days, and includes counselling, as well as referral to treatment programs and housing.

Central City Concern offers a wide range of housing alternatives, some of which provide addiction group-therapy programs and referrals to other agencies. In some of its facilities, several floors are, at the request of residents, designated alcohol- and drug-free. One facility offers basic

[400] The Hooper Center is named in honour of the last intoxicated person to have died in the Portland City Jail.

low-barrier housing for chronic alcoholics who are frequent users of the Hooper Center but who are not ready for the detoxification program.

4. A proposed approach for Vancouver

During the course of this inquiry I have learned enough about the plight of homeless chronic alcoholics to realize that, while in some respects they are a clearly identifiable sub-cohort, they are in other respects part of a much larger group who experience homelessness, addiction and mental illness.

Responding to the unique needs of homeless chronic alcoholics must be undertaken in the context of that larger issue—an issue with which many in the caring professions, with a far deeper understanding than the Commission's, are already grappling.

It may thus be helpful to offer here some general observations that take into account, first, approaches that are not presently addressing the needs of homeless chronic alcoholics, and second, innovative programs that have developed in other jurisdictions, that should be considered here.

a. A civilian response

In spite of universal recognition that chronic alcoholism is a medical condition deserving of a medical or harm reduction response, Vancouver's continued reliance on police officers to enforce the "state of intoxication in a public place" legislation is a drain on scarce police resources, a punitive revolving-door policy that ignores the underlying housing, medical and social needs of chronic alcoholics.[401]

Many jurisdictions have successfully converted to an entirely civilian-based response. Portland, Oregon, for example, has developed an expertise in providing assistance to homeless chronic alcoholics—even sometimes violent ones—in which their Hooper Center is an entry point to a continuum of care. It is time for Vancouver to move toward a similar type of civilian response.

[401] I do not mean to suggest that the VPD favours retention of the current punitive approach. For more than a decade, the department has been advocating a civilian-based harm reduction response to public inebriation.

To be effective, it may be necessary for civilian first responders to have some form of statutory authority to detain people who are incapacitated by alcohol or drugs, until they are capable of managing their own affairs.

b. Housing first

The literature reviewed by the inquiry emphasizes the importance of safe and stable housing as essential in any strategy to assist homeless chronic alcoholics. Such housing should have two components:

- No strings attached

  Housing should be seen as a fundamental human right, and it should not be tied to abstinence or willingness to accept treatment. The reality is that some chronic alcoholics may never detoxify successfully, let alone progress to treatment. However, providing safe and stable housing with no strings attached (perhaps in conjunction with a managed alcohol program) leads to incremental benefits, such as physical security, stabilized and reduced alcohol intake, improved nutrition and access to medical care.

- Low-barrier

  Homeless chronic alcoholics are often described as the "hardest to house" because of their disruptive and sometimes violent behaviour. Low-barrier housing functions as a safety net for those who cannot access or maintain housing in market, subsidized or supported housing. It is sometimes described as housing with a "no evictions" policy, in recognition that eviction means a return to life on the streets. The Simon Fraser University study mentioned earlier describes this target population as follows:

  > This group is the most disruptive and is the group that media and others refer to when describing the increasing public disorder on the streets. They typically have complex health issues; active and severe addictions, untreated or marginally effectively treated mental illness, and a host of physical health issues related to homelessness and substance use. Their survival behaviours and behaviours related to untreated mental illness are highly problematic, causing significant

public order issues when homeless and significant challenges to housing providers when indoors.[402]

c. Assertive community treatment

Because of the unique needs of this group of people, housing alone is often not enough. The Victoria Mayor's Task Force report mentioned earlier emphasizes the importance of community-based, multidisciplinary teams that provide support, treatment and rehabilitation services to clients where they live, and that are on call 24 hours a day to support clients through crises and emergencies.

d. Palatable alcohol substitution and managed alcohol programs

Programs such as those in Toronto and Ottawa mentioned earlier have learned from experience that an abstinence approach is not always successful. Sometimes a harm reduction approach is a preferable response, which may include:

- swapping a resident's potentially deadly mouthwash or cooking wine for palatable wine, or
- giving a resident a measured amount of wine every hour, to avoid bingeing and to stabilize and eventually reduce the amount consumed.

5. Learning from our mistakes

As I noted earlier, between 1998 and 2003, the City of Vancouver, the Vancouver/Richmond Health Board (now the Vancouver Coastal Health Authority) and the provincial Ministry for Children and Families put a great deal of effort into developing plans for an acute intoxication intervention program in the Downtown Eastside. Regrettably, the plan was never realized. Although the evidentiary record is not clear as to the reasons why this initiative failed, one can readily envisage the challenges when two levels of government and a quasi-independent health authority were involved.

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[402] Patterson, Michelle, et al. "Housing and Support for Adults with Severe Addictions and/or Mental Illness in British Columbia." (Vancouver: Centre for Applied Research in Mental Health and Addiction, Faculty of Health Sciences, Simon Fraser University, 2008), p. 133. See http://www.carmha.ca/publications/index.cfm?contentID=29.

We can, and should, learn from the past. If there is governmental endorsement of my analysis and recommendations, then we must ensure that the key stakeholders are involved in the development of a comprehensive response to the needs of homeless chronic alcoholics, which should include representation from at least the following:

- the City of Vancouver,
- the Vancouver Coastal Health Authority,
- the provincial Ministry of Housing and Social Development, and
- the Aboriginal community, as determined by that community.[403]

In recognition that each of these parties has its own areas of responsibility, with competing claims over limited resources and funding, it would be asking too much to expect one of them to assume leadership of this initiative. Consequently, I propose that the Lieutenant Governor in Council appoint a highly respected third party, knowledgeable about the issues but independent of any of the interests involved, to assume an overall leadership role in the development of the response.

In order to ensure that this process stays on track and reaches fruition, I would invite the provincial Ombudsman, if the Ombudsman considers it appropriate, to monitor progress and, after one year, to make a special report to the Legislative Assembly and comment publicly on progress made on this initiative.[404] The Ombudsman's authority to do so is found in section 31(3) of the *Ombudsman Act*,[405] which states as follows:

> Annual and special reports
>
> 31(3) If the Ombudsman considers it to be in the public interest or in the interest of a person or authority, the Ombudsman may make a special report to the Legislative Assembly or comment publicly about a matter

[403] In my view it is essential that the urban Aboriginal community participate fully in the development of a comprehensive response to the needs of homeless chronic alcoholics, given the fact that Aboriginals are grossly overrepresented among homeless chronic alcoholics in the Downtown Eastside and the need for culturally appropriate facilities and programs.
[404] The Ombudsman is well positioned to perform this function, given that the Ombudsman's jurisdiction extends to provincial ministries, municipalities and regional health boards.
[405] R.S.B.C. 1996, c. 340.

relating generally to the exercise of the Ombudsman's duties under this Act or to a particular case investigated by the Ombudsman.

D. Recommendations

1. **I recommend that the City of Vancouver, the Vancouver Coastal Health Authority, the provincial Ministry of Housing and Social Development, and the Aboriginal community jointly develop a comprehensive response to the needs of homeless chronic alcoholics within the city of Vancouver. This would include (but not be limited to) the following components:**

   - **a civilian-operated program for attending to chronic alcoholics who are incapacitated in a public place,**
   - **a civilian-operated sobering centre,**
   - **an enhanced civilian-based detoxification program,**
   - **the provision of permanent low-barrier housing designed for the specific needs of chronic alcoholics, which would offer (if needed) palatable alcohol substitution and managed alcohol programs, and**
   - **the provision of community-based, multidisciplinary assertive community treatment services.**

2. **I recommend that the Lieutenant Governor in Council appoint a highly respected third party, knowledgeable about the issues but independent of any of the interests involved, to assume an overall leadership role in the development of the response.**

3. **I recommend that the provincial Ombudsman—if the Ombudsman is agreeable—monitor progress of the comprehensive response for a three-year period and on an annual basis make a special report to the Legislature and comment publicly on progress made on this initiative.**

PART 6—THE CRIMINAL INVESTIGATION OF POLICE-RELATED DEATHS

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Interim Report of the Davies Commission of Inquiry into the death of Frank Paul

A. Introduction

1. The meaning of "police-related deaths"

In this report I use the term "police-related deaths" to include a wide variety of factual circumstances, including (but not limited to) a death in a police department jail cell, a death resulting from an officer's use of force, a death while detained at the roadside or in a police cruiser, or a death arising from, or soon after, some other form of police interaction with the deceased (such as in the Frank Paul case).

When a death occurs in these types of circumstances, there is understandable public concern. Given the authority that our society vests in police officers to use force when necessary to enforce our laws and ensure the safety of our communities, the public is entitled to an assurance that the officer's conduct was proper and, if force was used, that it was reasonable.

2. The police response to police-related deaths

When a police-related death occurs, two types of police investigations typically result:

- A *criminal investigation*, to ascertain whether a police officer's action or inaction constitutes a criminal offence. Frequently, such an investigation will focus on whether the officer used excessive force, was criminally negligent, or breached a legal duty to provide necessaries of life to a person under the officer's care.

- A *professional standards investigation*, to ascertain whether a police officer's action or inaction constituted a breach of a professional duty. If such a breach is established, the officer would face internal disciplinary proceedings.

In the Frank Paul case, both types of investigations occurred and, as I stated earlier in this report, I concluded that there were inadequacies in both.

In this part of the report, I will examine the current policies and procedures governing criminal investigations arising out of police-related deaths, and will recommend reforms.

In the next part of the report, I will examine the current policies and procedures governing professional standards investigations arising out of police-related deaths, and will recommend reforms.

B. A Description of the Current Practice

1. Ordinary homicide investigations

During the evidentiary hearings, Insp. Porteous, the officer in charge of the VPD's Major Crime Section (that includes the Homicide Squad), explained the current policies and practices relating to suspicious deaths, and the special rules applicable to certain types of police-related deaths. Later, in our policy roundtable discussions, counsel for the department guided me through the policies contained in the department's *Regulations and Procedures Manual*.[406]

According to section 15.09 (Sudden Death) of the VPD's manual, whenever a sudden death is reported, the E-Comm (911) dispatcher must assign an Operations Division unit to investigate.[407] When that unit ascertains that a sudden death is suspicious in nature, or involves suicide or accident, the Field Supervisor must be notified. If the circumstances are suspicious, the Field Supervisor must secure the scene and notify the Homicide Squad as soon as practicable. The initial investigators are responsible for identifying the deceased and notifying of next of kin. In every sudden death, the Coroners Service must be notified.

Section 18.02 (Major Crime Scene Responsibilities) of the manual sets out the procedures to be followed in major crime incidents generally. In a separate paragraph dealing specifically with homicides, it repeats many of the same instructions and directs the first officer on the scene to:

- clear the area of suspects and ensure that injured persons are treated and removed to medical facilities,
- advise the area Supervisor,
- hold all witnesses and limit conversation between them,

[406] Some sections of the VPD's *Regulations and Procedures Manual* are available at http://vancouver.ca/police/Planning/RPM/RPM.pdf.
[407] See VPD's *Regulations and Procedures Manual*, "Investigations – 15.09 Sudden Death."

- hold and separate all suspects, seize the suspect's clothing if there is a possibility of evidence being recovered from them, remove suspects from the scene and have them taken to headquarters for interview by the follow-up investigators, and never return a suspect to a crime scene,
- secure the crime scene for the Forensic Identification Squad using police barrier tape, and do not allow anyone entry beyond the barrier tape until the Forensic Identification Squad has taken responsibility for the scene,
- request that the Central Dispatcher notify the Duty Officer, the Forensic Identification Squad and the Homicide Squad,
- advise the Forensic Investigation Squad and the Homicide Squad investigators of all known facts about the crime scene, and make a rough sketch of the crime scene.

When the Forensic Identification Squad attends a homicide scene, it must take charge of the crime scene and is responsible for the overall coordination and direction of the crime scene examination.

2. Investigation of police-related deaths

The manual deals specifically with only two types of police-related deaths—deaths occurring in a jail, and deaths resulting from an officer's use of force.

a. Deaths in jail

When a Jail staff member discovers a death in a jail, he or she must alert the Jail Control Officer. The Control Officer must notify the Jail NCO immediately, lock down the scene to all but essential medical personnel, and document all emergency responses. The Jail NCO is required to seal off the cell or area where the incident occurred; report the death to the Duty Officer, the inspector in charge of Court and Detention Services, and the coroner; arrange for an investigation by the Major Crime Section; and ensure that Jail guards complete written statements for assigned investigators.

b. Statements and duty reports

Section 47.04 (Statements and Duty Reports) of the manual is limited in its application to situations in which an officer's *use of force* has resulted in a serious injury or death. The Major Crime Section investigates such

incidents. The investigator is required to order a duty report from any officer who was directly involved in the application of force (respondent officer).

The manual has detailed provisions respecting the respondent officer's right to counsel, before submitting a duty report:

- The respondent officer may consult with legal counsel and a Vancouver Police Union representative before providing a duty report.
- Under the collective agreement, the employer is obligated to pay the respondent officer's necessary and reasonable costs for up to a two-hour consultation with a lawyer as to whether the officer should make a statement and, if so, in what form. This obligation arises if the respondent officer
    - ♦ learns that an allegation has been made that the member misconducted himself or herself in the performance of the officer's duties;
    - ♦ reasonably believes that the allegation may result in the initiation against the respondent officer of proceedings under the *Criminal Code*; and
    - ♦ has been asked by the employer or a person in authority to make a statement to anyone about the facts connected with the allegation.
- In recognition that two hours of consultation may not be enough, the inspector in charge of the Professional Standards Section will authorize the employer to pay for up to 10 hours, to consult with a lawyer and to prepare a duty report.
- The inspector may authorize the employer to pay for the respondent officer's consultation with a lawyer in excess of the 10 hours.

Before completing the duty report, the manual requires that the respondent officer be provided with:

- A copy of the CAD printout related to the incident being investigated, to provide more accurate accounting in the duty report.
- A list of issues that the Major Crime Section needs to have addressed in the duty report. This will ensure that the duty report

is complete and that it includes all of the information required by the Major Crimes Section to complete the investigation.

The respondent officer must submit the duty report within a reasonable period of time or as soon as possible. In any event, it must be provided within five business days of being ordered, which is described as five normal working days, not including weekends or statutory holidays. The chief constable or designate may extend this time limit in extenuating circumstances. The manual is silent as to whether the investigator should conduct a face-to-face interview of the respondent officer or whether the officer must submit to an interview.

The procedure is significantly different for other officers who were involved in, or witnessed, the incident (witness officers):

- They are entitled to Vancouver Police Union representation, but are not usually entitled to legal counsel before providing a duty report or a witness statement.
- If they are concerned that they may become a respondent, they should be given an opportunity to discuss this with a lawyer.
- They are to provide their statements before going off duty (and shall not go off duty without permission), unless the lead investigator gives permission.

C. The Report to Crown Counsel

1. When is a Report to Crown Counsel submitted and what should it contain?

Before discussing the procedure in police-related deaths, I will briefly describe the general practice applicable to all criminal offences in which the potential accused is not a police officer. When, at the conclusion of any criminal investigation, an investigating officer concludes that criminal charges are warranted, the officer completes a Report to Crown Counsel, including the officer's opinion respecting what charge or charges are warranted. Crown Counsel are criminal lawyers employed in the Criminal Justice Branch of the Ministry of Attorney General. Based on Crown Counsel's review of these Reports to Crown Counsel, they decide what criminal charges (if any) should be laid, and conduct prosecutions on behalf of the Crown.

The VPD's manual does not state what should be included in a Report to Crown Counsel. However, the *Crown Counsel Policy Manual*[408] does. The general "Charge Assessment Guidelines" policy (CHA 1) can be summarized as follows:

- A police's Report to Crown Counsel should provide an accurate and detailed statement of the available evidence. The basic requirements for every report include:
  - a comprehensive description of the evidence supporting each element of the suggested charge(s),
  - when the evidence of a civilian witness is necessary to prove an essential element of the charge, a copy of that person's written statement,
  - necessary evidence check sheets,
  - copies of all documents required to prove the charge(s),
  - a detailed summary or written copy of the accused's statement(s), if any,
  - the accused's criminal record, if any, and
  - an indexed and organized report for complex cases.
- If the Report to Crown Counsel does not comply with these requirements, Crown Counsel may return it to the investigator with a request outlining the requirement to be met.

Several important conclusions can be inferred from this policy. First, it presumes that the police will forward a Report to Crown Counsel only when the police conclude that criminal charges are warranted. Second, it is expected that the police will identify which criminal charge or charges are warranted, and what evidence supports each charge. Third, the policy does not, in the case of deaths, differentiate between investigations of police-related deaths and other deaths.

2. Criminal investigations of police-related deaths

The practice in the investigation of police-related deaths is significantly different. Within the VPD there is a longstanding unwritten policy that, in police-related deaths:

- *all* investigations result in a Report to Crown Counsel, and

[408] See http://www.ag.gov.bc.ca/public/criminal-justice/CJBPolicyManual.pdf.

- the Report to Crown Counsel is neutral, in the sense that the investigating officer makes no recommendation as to whether criminal charges should be laid and, if so, for what offences.

During the evidentiary hearings Insp. Porteous, the officer currently in charge of the Major Crimes Section, was asked why this policy exists. He replied:

> ... my understanding of it, Mr. Commissioner, is that ... it's given to Crown Counsel to ensure that there is a neutral third party that makes the determination as to whether or not charges do or do not get laid so that there's not any kind of perception of bias or subjectivity on the part of the police.... [W]e have a mechanism in place where we're trying to—certainly the policing community has come under great scrutiny over the last several years about objectivity and, therefore, the mechanism's in place for not recommending – not recommending charges and leaving that to Crown Counsel is [*sic*] because they're independent of us.[409]

3. Crown Counsel procedures in police-related deaths

The Criminal Justice Branch is equally cautious in its consideration of charge assessments in such cases. One section of its policy manual (POL 1) deals with "Allegations Against Peace Officers." The policy states:

> In order to ensure that there is no perception of a conflict of interest and to maintain public confidence in the administration of criminal justice, the charge assessment decision on an allegation against a peace officer must be made by either Regional Crown Counsel or the Director, Legal Services.
>
> Regional Crown Counsel should make the charge assessment decision unless concerned that there could be an objectively reasonable perception of a conflict of interest or that the maintenance of public confidence in the administration of justice requires that the decision should be made at Headquarters. In either case, the matter should be referred to the Director, Legal Services for a charge assessment decision, pursuant to the procedure set out below.

Where there is an allegation that a peace officer's actions caused death, the policy manual requires that the Director, Legal Services, provide a copy of the material to the Assistant Deputy Attorney General.

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[409] Transcript, February 21, 2008, p. 35.

One can readily understand how this policy developed. Line prosecutors have daily dealings with local police officers, during charge assessment discussions and when calling police officers to testify for the Crown during criminal trials. Some might consider it unreasonable, when a local officer is suspected of committing a criminal offence, to expect such prosecutors to be completely objective in making charge assessment decisions.

In such circumstances, it is not surprising that the Criminal Justice Branch would assign charge assessment decisions to more senior prosecutors who are removed from these local dynamics. Even then, it may be necessary to have the charge assessment decision made at headquarters, if the senior prosecutor has had previous dealings with the specific police department or officer.

Similarly, there is good reason to alert the Assistant Deputy Attorney General when there is an allegation that a peace officer's actions caused death, and to assign charge assessment decisions to a senior criminal lawyer in private practice (a special prosecutor), when a "senior police officer" is alleged to have committed a criminal offence.

D. The Problem of Divided Loyalties When the Home Department Investigates Police-Related Deaths

Based on my review of the evidence I heard about the VPD's current practices for investigating police-related deaths, and based on my examination of the department's and Crown Counsel's policies and procedures reflected in their policy manuals, I am persuaded that the current practice of a home police department conducting criminal investigations of police-related deaths is fundamentally flawed, and that nothing short of a wholesale restructuring of such investigations will suffice.

The fundamental flaw that lies at the heart of the current practice is conflict of interest and duty or, in this circumstance, divided loyalties. In the same way that a client is entitled to expect their lawyer to act with undivided loyalty to their interests, to the exclusion of all other personal and professional interests, so too 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.

In my view, it is too much to ask the public to accept that divided loyalties will not influence a home police department's criminal investigation of a police-related death.

During our policy roundtable discussions, Insp. De Haas was asked about the "thin blue line," the suggestion that police officers will rally around a fellow officer who is alleged to have misconducted himself or herself. He stated in part:

> I think what I heard was the perception that perhaps the organization wishes to protect other police officers who may have misconducted themselves or be under investigation for that.... [W]hen the line is clearly crossed there is certainly a desire within the profession to get rid of those who ought not to be in the organization.[410]

While I accept Insp. De Haas's general assertion that individual police officers and policing organizations do not countenance clear instances of police misconduct or criminality, many situations are much more subtle, especially during the early stages of a criminal investigation. It is quite reasonable to expect an officer's colleagues or the department itself to be sympathetic to the view of an incident from the officer's perspective. One would expect no less from one's professional colleagues.

However, we then expect them to investigate the officer's conduct and decide, in a completely impartial manner, whether the officer has committed a criminal offence. The divided loyalties are obvious. Even if the criminal investigation is conducted impartially, one cannot fault the public for being distrustful of the process, especially if no criminal charges result.

Conflict of interest finds expression in several aspects of the current policy, to which I now turn.

1. The municipality's legal liability for a police officer's misconduct

When a municipality chooses to establish its own police department, it does so through a municipal police board, which is responsible for appointing a chief

[410] Transcript, May 6, 2008, pp. 82–83.

constable and other constables and employees, all of whom are employees of the board.[411]

Normally, a private citizen or an employee of a corporation is personally liable, criminally and civilly, for their acts or omissions. In the case of municipal police officers, the situation is different. While they remain liable for criminal acts, section 21 of the *Police Act* exempts them from a civil action for damages for anything done, or omitted to be done, in the performance of their duties or in the exercise of their power; or for any alleged neglect or default in the performance of their duties or exercise of their power. However, this protection does not apply if the officer has been guilty of dishonesty, gross negligence or malicious or willful misconduct, or if the cause of action is libel or slander.

Even though the individual officer may be exempt from civil liability, two provisions of the *Police Act* make it clear that the municipality is civilly liable:

- section 21(4) states that this section does not absolve the municipality from vicarious liability arising out of a tort committed by the officer, and
- section 20(1)(a) states that a municipality is jointly and severally liable for a tort that is committed by any of its municipal constables or employees of its municipal police board, if the tort is committed in the performance of that person's duties.

In other words, while the *Police Act* may protect an individual police officer from civil liability for misconduct such as excessive use of force or wrongful imprisonment, the municipality remains liable.[412] It is therefore in the interests of the municipality to minimize its legal exposure—which leads to a risk that it will do so by adopting policies or endorsing procedures that downplay the officer's misconduct. It is an instance of a departmental conflict of interest; its interest in minimizing its civil liability conflicts with its duty to the public interest to hold its officers to account for misconduct.

2. Investigative treatment of respondent officers

When a civilian is suspected of causing a death, the practice of the police is to arrest the suspect, advise them of their rights under the *Charter of Rights and*

[411] *Police Act*, s. 26(1) and (3).
[412] *British Columbia (Attorney General) v. Insurance Corporation of British Columbia*, (2008) S.C.C. 3.

Freedoms and then take them to the police station. Should the suspect request an opportunity to consult with legal counsel, the police must hold off their questioning until that consultation has taken place. Thereafter, it has been held to be lawful for police officers to aggressively question a suspect, notwithstanding repeated assertions by the suspect that he or she does not want to talk to them.[413]

In the case of a police-related death, the situation is markedly different. According to Insp. Porteous, the first group to have access to the officer at the scene is the department's post-critical incident trauma team, followed by the Vancouver Police Union's representative.[414] The officer is not detained, and the practice is that the officer is neither subjected to a face-to-face interview nor interrogated. The officer's only obligation is to submit a duty report, and the officer may have up to five business days to do so. In preparation of the duty report, the officer:

- is entitled to up to 10 hours of legal consultation, paid for by the department,
- is provided with a CAD printout related to the incident being investigated,
- is provided with a list of issues that the Major Crimes Section needs to have addressed in the duty report, and
- may claim overtime for the time required to complete the duty report.

I do not question that a police-related death may be traumatizing to the respondent officer, and my chronicling of what steps are followed in a police-related death is not meant as a criticism; it is intended rather to illustrate the procedural differences between civilian-caused deaths and police-related deaths.

What this comparison clearly shows is that in a police-related death the respondent officer receives in some respects differential treatment, which reflects

[413] *R. v. Singh*, 2007 S.C.C. 48.
[414] Transcript, Feb. 21, 2008, pp. 47–48.

a legitimate concern for the officer's welfare.[415] However, this very fact raises concerns about conflict of interest. While it may be entirely appropriate for a respondent officer to be dealt with in this manner, the public cannot be faulted for questioning the objectivity and impartiality of the same police department's ensuing criminal investigation. It is another instance of divided loyalties.

3. "Neutral" Reports to Crown Counsel

As noted earlier, the Report to Crown Counsel is different in the case of a police-related death, than in all other criminal investigations, in two significant respects:

- *all* police-related deaths result in a Report to Crown Counsel, and
- the Report to Crown Counsel is "neutral," in the sense that the investigating officer makes no recommendation as to whether criminal charges should be laid.

Insp. Porteous testified that the unwritten policy underlying this practice is to ensure that the decision to charge or not to charge an officer with a criminal offence, is made by a neutral and independent third party. This policy and practice is an implicit admission of what to many would seem obvious—that the home police department may not be neutral and independent in such matters.

However, in my view the problem runs deeper. If the need for neutrality and independence precludes the police department from making a recommendation about whether criminal charges are warranted, then the department should be disqualified from conducting the criminal investigation that precedes the charge approval process.

To put it another way, the VPD has quite properly identified the conflict of interest inherent in its criminal investigation of police-related deaths, but its decision to file "neutral" Reports to Crown Counsel is not a solution, as it does not eliminate the underlying conflict of interest found in conducting the

[415] In one respect, the VPD imposes a higher duty on a respondent officer to assist in a criminal investigation, than the law imposes on a private citizen who is under investigation. A private citizen has an absolute right to remain silent during a criminal investigation, whereas a respondent officer must complete a written duty report. Having said that, a duty report may not be admissible against a respondent officer in any resulting criminal proceedings, since it was made under compulsion: see *R. v. White* (1999), 135 C.C.C. (3d) 257 (S.C.C.).

investigation itself. Instead, the neutral Report to Crown Counsel introduces *new* problems, such as the risk that important inconsistencies and difficult issues arising in the evidence may not attract the critical attention they merit.

4. Crown Counsel's different charge assessment procedures

I preface this discussion by noting that the rules, policies and procedures of the Criminal Justice Branch have not been fully explored in the inquiry's proceedings, because of the branch's legal challenge. Consequently, I do not have the advantage of the branch's input on these issues. However, I do have access to the *Crown Counsel Policy Manual*, as well as a considerable body of evidence and information that addresses the police practice in preparing these "neutral" Reports to Crown Counsel.

As discussed earlier, the Criminal Justice Branch has developed different charge assessment procedures for when a police officer is alleged to have committed a criminal offence. The *Crown Counsel Policy Manual* explicitly attributes this different policy to concerns about conflict of interest and the need to maintain public confidence in the administration of criminal justice. Although the policy does not elaborate on the nature of the conflict of interest, I am satisfied that it arises out of the close working relationship that exists between prosecutors and police officers in a particular community. It is inevitable that a camaraderie will develop over time, even though both have professional duties to act independently in their own spheres of activity.

If such camaraderie between professionals, who work in separate organizations, precludes a prosecutor's involvement in the charge assessment process when a police officer is alleged to have committed a criminal offence, would there not be a greater risk of conflict of interest when the officers conducting the criminal investigation and the respondent officer are colleagues in the same organization?

One finds another instance of the Criminal Justice Branch's concern about conflict of interest (or even public perception of it) in policy SPE 1. When a "senior police officer" is alleged to have committed a criminal offence, the charge assessment task must be assigned to a "special prosecutor," an experienced criminal lawyer from outside the ministry.

I would add that filing a "neutral" report with no recommendations renders Crown Counsel's task particularly difficult, since Crown Counsel has no investigative capacity independent of the police. Indeed, the Crown Counsel policy suggests that, if any additional police investigation is required, it is up to Crown Counsel to make the request, as occurred in the Frank Paul investigation (to obtain a statement from Cst. English).

E. A Note about the Scope of My Analysis and Recommendations

1. Applicability to all municipal police departments

Given that Frank Paul died within the city of Vancouver, and given that it was officers of the VPD who had dealings with him shortly prior to his death, it was appropriate that this inquiry's Terms of Reference would invite me to focus my recommendations on the role of the VPD.

However, as I examined the issue of the police investigating themselves, it soon became apparent that I should not limit my analysis to Vancouver alone, for several reasons. First, it would be artificial to do so. To the extent that conflict of interest may well be present in other departments' policies and practices respecting investigations of police-related deaths, any reforms that I propose should, logically, extend to those forces as well. Second, when examining some of the essential elements of a new system, such as cost (as I will discuss later), one needs to know how many police departments will be participating in the new system.

In taking a broad view of this issue, I recognize that I was not asked to undertake, nor have I undertaken, a detailed analysis of these other municipal police departments' policies and procedures. I am also aware that four Lower Mainland departments (West Vancouver, New Westminster, Port Moody and Abbotsford) rely on the RCMP's Integrated Homicide Investigation Team to conduct criminal investigations of police-related shootings and in-custody deaths.

However, if there is general acceptance of my conclusion that no amount of tinkering can remedy the inherent conflict of interest that permeates a home police department's criminal investigation of police-related deaths, then a new system needs to be developed which logically ought to apply to all municipal police departments. I note that there is no suggestion in the *Crown Counsel*

Policy Manual that matters from other municipalities are handled differently. My recommendation could be framed solely as it relates to the VPD, but that would not only be illogical but it would also fall short of meeting the public interest I have identified here.

2. Police-related deaths, or police-related deaths and serious injuries?

Throughout this report I have limited my discussion to police-related *deaths*. I appreciate that it is sometimes only good fortune that separates serious injury from death, and that the conflict of interest that jeopardizes the integrity of police-related death investigations applies with equal force to investigations of police-related serious injuries. I note that in Ontario the mandate of the Special Investigations Unit (SIU) extends to serious injuries and deaths involving municipal police (as well as the Ontario Provincial Police), and this mandate has been interpreted to include firearms injuries and deaths, custody injuries and deaths, motor vehicle injuries and deaths, and sexual assault.

I have decided not to include the investigation of police-related serious injuries in my recommendations for several reasons. First, the fact pattern that was before me involved a police-related death. I concluded that conflict of interest probably contributed to what I find to be an unsatisfactory criminal investigation in that case, and I am willing to extrapolate from that incident the existence of a risk that conflict of interest could taint other police-related death investigations. However, without a firmer evidentiary basis, it would be imprudent for me to extrapolate any further, to cases of serious injuries.

Second, while I am confident that a new system is required and should be established for all municipal police departments without delay, there is merit in proceeding incrementally when it comes to defining the mandate of this new system. Prudence suggests that we begin with the most serious category of cases first. Then, after developing policies and practices, and gaining valuable on-the-ground experience, the decision can be made whether the mandate should be broadened and, if so, how much.

F. Developing a New System for the Criminal Investigation of Police-Related Deaths

1. Essential elements

Having concluded that the current practice of a home police department conducting criminal investigations of police-related deaths is fundamentally flawed due to conflict of interest, it follows that no amount of tinkering with the current practice can eliminate that underlying conflict of interest. The challenge lies in developing a new system for the investigation of police-related deaths.

In considering what recommendations to make, I found it helpful to conceptualize the issue in terms of a spectrum. At one end of the spectrum we have the current practice, in which a home police department conducts criminal investigations of police-related deaths. At the other end of the spectrum we have a totally independent and impartial civilian body established to conduct such sensitive investigations. Ontario's SIU is an example of this type of civilian body.

Between the two ends of this spectrum are any number of intermediate options, such as: another police department; an ad hoc team of investigators drawn from other police forces on an as-needed basis; a dedicated team of investigators (such as the RCMP Integrated Homicide Investigation Team); or some combination of police and civilian investigators.

Many factors need to be considered before deciding on the most appropriate option for British Columbia. It is important that those factors be clearly articulated, so that there is transparency to the process. At the end of the day, the litmus test of success will be public support.

I have identified several essential elements that, in my view, should shape a new system for the investigation of police-related deaths. I will discuss them in turn.

a. Independence

If conflict of interest is the Achilles heel of the current system, then any new regime must move the criminal investigation of police-related deaths outside the home police department. Those who investigate such deaths must be independent from the home department so that the concern about divided loyalties does not arise. Indeed, I would go further. Those

investigating such deaths must be so far removed from the home department that reasonable members of the public would not even perceive a conflict.

Returning to the spectrum analogy, it is probably accurate to say that the farther away one moves from the home police department end of the spectrum, the less concern one has about divided loyalties, and the more confidence the public can have that investigations will be independent.

Opinions will differ whether the necessary degree of independence will be achieved by assigning criminal investigations of police-related deaths to another police force or to an ad hoc or dedicated team of police officers. Some may say that it is still the police investigating themselves, that thin blue line loyalties may undermine a separate department's impartiality. Others may respond that the PCC's experience in relying on outside police departments to conduct some professional standards investigations (which I will discuss in Part 7) demonstrates that they can act independently and impartially.

In my judgment, once it is decided that criminal investigations of police-related deaths must be removed from the home police department, we should choose an alternative that offers the greatest distance from conflict of interest and affords the highest degree of independence. While reliance on another police force or officers from ad hoc or dedicated teams to conduct these investigations *may* be adequate, it is equally true that they *may not*. All things considered (especially the issue of competence, to be discussed next), I favour moving these types of sensitive investigations as far away from the home police department as feasible, to achieve the greatest degree of independence and to address concerns about perceptions.

b. Competence

One of the arguments that has been advanced historically to justify keeping the investigation of police-related deaths in-house (or at least within a neighbouring police department) is that they can be complex, requiring the special training and skills that only experienced police

officers possess. For example, evidence must be collected and preserved, and statements from suspects must be taken, in a manner that will render them admissible at trial.

While I agree that competence is crucial and that using currently serving, experienced homicide investigators would promote competency, other jurisdictions have found other ways to address this concern; for example, through specialized training programs and the employment of former or retired police officers for some purposes.

c. Capacity to respond immediately

Experienced police officers know the crucial importance of responding immediately to a suspicious death, identifying and questioning suspects, sealing off the incident scene, separating suspects and witnesses, conducting a thorough forensic investigation, and preserving evidence.

Whatever system is developed to replace the current practice, the capacity to respond immediately will be essential.

d. Access to specialized services

Whoever investigates police-related deaths must be able to provide complete forensic identification services at the scene and have full access to other specialized services as needed (e.g., ballistics, hair and fibre analysis, toxicology, DNA analysis), as well as the ability to provide sufficient personnel resources to undertake neighbourhood searches or door-to-door canvasses.

e. Ability of smaller police departments to participate

In deciding which organizational structure would be most appropriate, consideration must be given to the geographical configuration of municipal police departments in British Columbia, and their relative sizes. There are currently 11 municipal police departments in the province—four in Greater Victoria, six in the Lower Mainland and one in

the Kootenays. Significantly, Vancouver (pop. 578,041) accounts for almost half the population of these 11 municipalities.[416]

If a home police department is disqualified from conducting criminal investigations of police-related deaths arising in its own municipality, then British Columbia's largest municipal police department (City of Vancouver) will be precluded from conducting, or contributing officers to, approximately half of all such investigations. This necessitates an examination of the human resources capacity, financial ability, and expertise of other police departments to conduct such investigations.

f. Cost

Currently, a home police department bears the cost of conducting a criminal investigation into a police-related death arising in its own municipality. If such investigations will in the future be done by another police department, or by some form of police-based or civilian-based investigative body, then it will be important to consider the cost and who should pay.

g. Accountability

Whatever new system for the criminal investigation of police-related deaths is implemented, it must ensure that there is an appropriate level of accountability, with respect to the substantive decisions made and the processes followed.

2. Alternative organizational approaches

I now turn to a consideration of the various organizational options for the criminal investigation of police-related deaths in the British Columbia municipalities policed by the 11 municipal police departments. Since the geographical configuration and relative sizes of the municipal forces bears on several of these options, it will be useful to set out that information here (Table 1):

[416] Statistics Canada 2006 Census; see http://www12.statcan.ca/english/census06/data/popdwell/Table.cfm?T=302&SR=1&S=1&O= A&RPP=25&PR=59&CMA=0.

Table 1: Population and police strength of municipal police departments[417]

Region	Municipality	Population	Police strength
Greater Victoria	Victoria (including Esquimalt)	96,066	221
	Saanich	110,737	147
	Oak Bay	18,059	22
	Central Saanich	16,768	21
Lower Mainland	Vancouver	589,352	1,214
	Abbotsford	129,685	195
	Delta	102,945	151
	New Westminster	57,645	107
	West Vancouver	46,764	79
	Port Moody	30,120	40
Kootenays	Nelson	9,923	17

a. Another municipal police department

If the home police department is disqualified from conducting a criminal investigation of a police-related death in its own municipality, then some would argue that such investigations should be assigned to either another municipal police department or to the RCMP (for my deliberations concerning the RCMP, see section f., "The RCMP as an alternative to municipal police investigations"), arguing that this would ensure prompt response, professional policing expertise, and access to specialized services.

[417] Police Services Branch, Ministry of Public Safety and Solicitor General. See http://www.pssg.gov.bc.ca/police_services/publications/statistics/1997-2006-policeresources.pdf.

Other than concerns respecting lack of independence, the ability of smaller police departments to participate in such investigations is brought into question, given the unique sizes and the configuration of municipal policing departments in British Columbia.

With respect to independence, reliance on another municipal police department is only one step removed from the home department, and would rely on serving police officers to conduct the investigation. This alternative does not eliminate concerns about the police investigating themselves. I am not satisfied that allowing another municipal police department to conduct these serious, and sensitive, investigations would achieve public confidence, which is an essential requirement of any new system.

With respect to capacity, this issue must be examined with an understanding of how municipal police departments are configured in the province, and the wide disparity in their sizes and, hence, their expertise to conduct homicide investigations.

In the Greater Victoria area, 86 percent of the population of the four municipalities with municipal police departments live in Victoria (including Esquimalt) and Saanich, so one would expect that almost all police-related deaths will occur in those two jurisdictions. The other two municipalities have such small police departments (each has only two detectives) that it is unrealistic to expect them (for reasons of human resources and expertise) to assume responsibility for a criminal investigation of a police-related death that occurred in either of the two larger jurisdictions. That means that every case arising in Victoria will have to be investigated by the Saanich Police Department, and vice versa. I am not satisfied that such a reciprocal arrangement would provide the necessary degree of independence.

In the Lower Mainland, there are similar concerns. The city of Vancouver's population accounts for 62 percent of the total population of all six Lower Mainland municipalities that have municipal police departments. This means that nearly two-thirds of all police-related deaths would likely arise in Vancouver, which means that they would need

to be investigated by one of the five other police departments. It is doubtful whether the three smaller departments have the human resources capacity, or the expertise, to conduct such investigations. If that is so, then all Vancouver-based police-related deaths would need to be investigated by the Delta or Abbotsford police departments. Assuming that they have the necessary expertise, this would place a heavy burden on those two departments. It would also raise concerns about their ability to respond promptly to a death, especially in the case of Abbotsford, which is approximately an hour east of Vancouver.

One additional concern about expertise arises from the fact that four Lower Mainland municipalities with municipal police departments (West Vancouver, Port Moody, New Westminster and Abbotsford) no longer conduct their own police shooting or in-custody death investigations, or any other homicide investigations. Rather, they contribute officers to the RCMP's Integrated Homicide Investigation Team.

In the case of Nelson, if a police-related death were to occur in that municipality, the resulting criminal investigation would need to be assigned to one of the Lower Mainland or Greater Victoria police departments, which would occasion considerable delay in arriving at the incident scene. It is probably fair to say that there would be logistical problems in responding to a police-related death in Nelson, whatever organizational alternative were adopted.

Based on this analysis, I am not in favour of assigning the criminal investigation of police-related deaths to another municipal police department. I am not satisfied that it would bring a necessary degree of independence and, given the disparate sizes and geographical configuration of municipal policing departments in British Columbia, I am not satisfied that an adequate level of expertise would be available in many cases.

b. A police-based investigatory team

The next step further removed from a home police department conducting criminal investigations of police-related deaths would be for

the six municipal police departments in the Lower Mainland, and the four municipal police departments in Greater Victoria, to contribute officers to joint task forces, which would conduct such investigations. This would be a variation on the RCMP's Integrated Homicide Investigation Team in the Lower Mainland, discussed earlier.

This alternative would likely be able to respond promptly to police-related deaths, and would have access to specialized services. However, it would also suffer from several deficiencies.

First, with respect to independence, it would still involve the police investigating themselves, which in my view would not instil a sufficient degree of public confidence.

Second, in terms of staffing and expertise, it would not be a significant improvement over the option of assigning such investigations to another municipal police department. In the case of Greater Victoria, neither the Oak Bay nor Central Saanich police departments have the staffing capacity to contribute a senior detective to such a joint task force, which means that the task force would consist exclusively of officers seconded from the Victoria and Saanich police departments. Since almost all police-related deaths will arise in those two municipalities, and since seconded officers from one of those municipalities would be disqualified from participating in an investigation arising within that municipality, it would result in officers from Saanich conducting investigations arising in Victoria, and vice versa. For all practical purposes, this alternative would look no different from the option discussed earlier, of police-related death investigations being assigned to another municipal police department.

In the case of the Lower Mainland, we can expect nearly two-thirds of all police-related deaths to arise within the city of Vancouver, which means that Vancouver police officers seconded to the task force would be disqualified from participation in all such cases. Consequently, we face the same dilemma of the three smaller municipal police departments (Port Moody, West Vancouver and New Westminster) having only limited capacity to contribute experienced serious crime investigators to the task force, which means that officers seconded from Delta and Abbotsford

would bear most of the responsibility for such investigations. As with Greater Victoria, a Lower Mainland joint task force would not be a significant improvement over the option discussed earlier of assigning such cases to another municipal police department.

Based on this analysis, I am unable to recommend this type of police-based investigatory team, for the investigation of police-related deaths.

c. A civilian-based investigatory team

Given the problems occasioned by assigning police-related death investigations to another municipal police department or to a police-based investigation team, some jurisdictions, such as Ontario, have established civilian-based investigation teams.

This approach eliminates concerns about independence and conflict of interest, because the police are no longer investigating themselves. However, concerns have been expressed about several other important issues, such as competence, ability to respond immediately and access to specialized services. In Ontario, this has led to police resistance to the Special Investigations Unit (SIU).

In considering whether to recommend a civilian-based investigation team model for British Columbia's 11 municipally-policed jurisdictions, I have reviewed the experience in Ontario. I will briefly review the SIU, because it will inform the discussion that must take place in British Columbia before final decisions are made respecting the criminal investigation of police-related deaths.

d. Ontario's Special Investigations Unit

In Ontario, home police departments have not investigated police-related deaths for 50 years—such investigations were assigned to other police departments. However, in 1988, after two black men were fatally shot by police, the provincial government appointed a Task Force on Race Relations and Policing, chaired by Clare Lewis. In 1989 Mr. Lewis recommended creation of an independent agency to investigate police shootings and to determine whether charges should be laid. This

investigative team, which would operate throughout Ontario, would be composed of homicide investigators chosen from various police forces other than the force involved in the shooting, together with at least two civilian members drawn from government investigative agencies independent of the Ministry of the Solicitor General. This recommendation was implemented through enactment of the 1990 *Police Services Act*. It established the SIU, for the investigation of deaths and serious injuries arising in the course of policing.

In 1992, after a riot on Yonge Street in Toronto, the government appointed Stephen Lewis as its advisor on race relations. He made recommendations on policing that included dealing specifically with the SIU. After noting concerns about the SIU's credibility, he rejected the suggestion from some communities that the unit should be composed only of persons with no past or present relationship with policing. He recommended additional funding, and that SIU should report to the Attorney General, not the Solicitor General. Although the government adopted the latter reporting recommendation, adequate resourcing of the SIU remained a persistent problem.

In 1995, the Commission on Systemic Racism in the Ontario Criminal Justice System concluded that the establishment of the SIU had not improved police accountability in the use of force. Three problems were identified: inadequate funding, lack of cooperation from police forces, and refusal of individual police officers to be interviewed. None of its recommendations were implemented.

In 1997, after SIU's investigations of a series of shootings of members of the public by the police, the Attorney General and the Solicitor General appointed the Honourable George W. Adams, Q.C., to consult with community and police organizations on ways to improve the relationship between the SIU and the police in three areas:

- timely notification of incidents to the SIU by the police,
- control of the incident scene pending arrival and investigation by the SIU, and

- timely cooperation of police officers involved in the incidents being investigated.

Mr. Adams released his *Consultation Report* on May 14, 1998, in which he made 25 consensus-based recommendations.[418]

The Attorney General appointed Mr. Adams again in 2003, to conduct a consultative review aimed at evaluating the implementation of the 1999 SIU reforms. In his resulting report[419] Mr. Adams did not make any additional recommendations, but his report offers a revealing window into SIU's growing pains since its inception in 1990, the policing community's initial resistance to this form of civilian oversight, and how improved funding has addressed concerns about SIU's competence, its ability to respond immediately to police-related deaths and its access to specialized services. Significantly, Mr. Adams reported that there now appears to be general acceptance by policing and community representatives of the civilian-based investigation team model:

> But I would be even more remiss not to emphasize at the outset that all stakeholder groups acknowledged that the reforms under review had achieved or were in the process of achieving their intended purpose and that there had been a vast improvement in the SIU's performance under the guidance of its current Director, Peter Tinsley. The increased public funding has provided the SIU with the resources necessary to carry out its important work in a manner in which police and community groups now have confidence. The regulatory changes have provided an effective regime for SIU investigations reinforcing that essential confidence. In short, real progress has been achieved due to the 1999 reforms.
>
> As important, all police and community representatives framed their proposals as intended to improve the SIU, not to replace it.[420]

In September 2008 the Ontario Ombudsman published the report of his Office's 15-month investigation into the operation of the Special Investigations Unit.[421] The Ombudsman, who had served as director of

[418] See http://www.siu.on.ca/adams.html.
[419] *Review Report on the Special Investigations Unit Reforms*. See http://www.siu.on.ca/adamsreview2003.pdf.
[420] Ibid., p. 12.
[421] *Oversight Unseen: Investigation into the Special Investigations Unit's Operational Effectiveness and Credibility*, available at http://www.ombudsman.on.ca/media/30776/siureporteng.pdf.

the SIU between 1996 and 1998, expressed the view that the SIU "is a significant and unique institution in Canadian society. It is an excellent model for criminal investigation of police" (p. 106). However, he was strongly critical of SIU's underperformance, the policing community's resistance to SIU authority and the provincial government's trenching on SIU's independence.

The Ombudsman found that the SIU, which he characterized as a fledgling organization, "continues to struggle to assert its authority, maintain its balance against powerful police interests, and carry out its mandate effectively" (p. 4). He said that delays in police providing notice of incidents, in disclosing notes and in submitting to interviews were endemic. Not only was the SIU complacent in ensuring that police officials follow the rules, but it had bought into the fallacious argument that SIU investigations were not like other criminal cases, and that it was acceptable to treat police witnesses differently from civilians. Police interviews were often postponed for weeks, and the SIU would not inconvenience officers or police forces by interviewing officers off-duty.

He reported that all of the SIU's investigative managers and most of its investigative staff were former police officials and that it was so steeped in police culture that it had, at times, even tolerated the blatant display of police insignia and police affiliation. He stated:

> The SIU was borne out of public distrust of police investigating their own. It is critical that the organization move swiftly away from the police ties that continue to hold it back from being a truly *civilian* oversight body (p. 106, emphasis in original).

The Ombudsman was also critical of the SIU's substantial reliance on the Ministry of the Attorney General for administrative and technical support, which was an impediment to its evolution as an oversight body. In his view,

> [T]he SIU and the Ministry**...** will have to change their practices, and the government will have to implement legislative reform if the SIU is to achieve its full potential. I believe that government has, at the very least, a moral obligation, to ensure that the institutions it creates are

> imbued with the structure, resources and tools necessary to fulfill their mandates (p. 107).

The Ombudsman's 46 recommendations were directed at the SIU, the Ministry of the Attorney General and the Province of Ontario. He called for new legislation dealing specifically with SIU's mandate and investigative authority, which should include a specific duty on police to cooperate—failure to cooperate would be made an offence punishable by fine or imprisonment. The director of the SIU should be appointed on a five-year renewable term, with compensation established objectively, and the director should not be subject to a Ministry performance assessment.

From my review of these reports, there appears to be a consensus that Ontario's SIU model is sound, but that its effectiveness and credibility are dependent on unequivocal provincial government support and resourcing, operational independence, police "buy-in," and competent civilian leadership and operational control. We can learn much from the SIU's growing pains.

During our policy roundtable discussions, Ontario's current Ombudsman made an informative presentation about the SIU. I can summarize the SIU's current mandate and activities as follows:

- Its mandate is to investigate the circumstances of serious injuries and deaths that may have resulted from criminal offences committed by police officers.
- It has jurisdiction throughout Ontario, which has a population of 12,160,282 (i.e., all municipal police departments and the Ontario Provincial Police).
- The director of SIU, who is an order-in-council appointee with a five-year term, cannot be a current or former police officer.
- SIU investigators cannot be currently serving police officers.
- Former police officers may be hired as investigators, but they cannot investigate officers from their former police force.
- When a police-related death or serious injury occurs, the chief of police must immediately advise SIU and, until SIU arrives at the incident scene, must ensure that the scene is secured and all officers involved in the incident are segregated from each other.

- SIU becomes the lead investigator, and has priority over any police force in the investigation.
- SIU currently has three investigative supervisors (currently all are former police officers) and 12 full-time investigators (just under half are former police officers) working out of its Mississauga office, and 27 part-time investigators (a majority are former police officers) located around the province who are deployed on an as-needed basis.
- SIU investigators have peace officer status.
- SIU has its own in-house Forensic Identification Section and laboratory, with a full-time supervisor and nine part-time technicians.
- SIU relies on the Centre of Forensic Sciences of Ontario for more sophisticated tests, such as DNA and ballistics analysis.
- SIU's annual budget is approximately $5.5 million.
- SIU investigates approximately 200 incidents each year. In 2006, it investigated 226 incidents and laid two criminal charges.
- The director decides whether criminal charges will be laid against a police officer.
- When the director approves charges, the prosecutions are conducted by a Crown attorney in the Justice Prosecutions section of the Ministry of the Attorney General, which is responsible for prosecuting those in the justice system who are charged by any authority.

e. Recent experience in other provinces

Alberta

In Alberta, the Department of Solicitor General and Public Security recently established the Alberta Serious Incident Response Team (ASIRT).[422] Its mandate is to investigate incidents or complaints involving serious injury or death of any person, and matters of a serious or sensitive nature, that may have resulted from the actions of a police officer. ASIRT, which is governed by section 46.1 of the *Police Act*, has jurisdiction over all sworn police officers in the province of Alberta.

[422] See http://www. solgps.alberta.ca/programs_and_services/public_security/policing/policing_0versight _complaints/Pages/asirt.aspx.

It has offices in Edmonton and Calgary, and is led by a civilian director, who is a lawyer and Crown prosecutor. Reporting to the director are a civilian assistant director, two civilian criminal analysts, four civilian investigators and 10 sworn police officers (from the Calgary Police Service, Edmonton Police Service, and the RCMP). The director may engage public overseers from the community to ensure independence in the investigative process.

Once an investigation has been completed, the director reviews the results of the investigation to ensure completeness and fairness. A report is then forwarded to the office of the Crown prosecutor, requesting an opinion on charges. The director will, after reviewing the opinion, decide what charges if any will result from the investigation.

Manitoba

In Manitoba, Attorney General David Chomiak announced on October 6, 2008, that he would implement all 14 recommendations of a public inquiry that called for the province to create an independent special investigations unit to probe police officers accused of criminal wrongdoing.[423] The inquiry, led by retired Justice Roger Salhany, Q.C., inquired into the death of a mother of three, who was killed when a truck driven by a Winnipeg police officer smashed into the rear of her car while she was stopped at a red light. The commissioner was strongly critical of the criminal investigation conducted by the East St. Paul police force, a small force for a community of 8,000 at Winnipeg's edge, which he described as "riddled with incompetence" and that was, in parts, "conducted in bad faith." He recommended:

> That the Minister of Justice give consideration to creating a provincial special investigative unit independent of all police enforcement agencies in Manitoba for the purpose of investigating any alleged criminal activity of a member of a police service.[424]

[423] The province would "put in place an Independent Investigations Unit to investigate alleged criminal activity of a member of a police service. The new unit will be established in a new *Provincial Police Act* to be introduced in the spring." See http://news.gov.mb.ca/news/index.html?archive=2008-10-01&item=4565.
[424] *Taman Inquiry into the Investigation and Prosecution of Derek Harvey-Zenk*, p. 139, available at http://www.tamaninquiry.ca/pdf/taman_inquiry_B.pdf.

He also observed that whatever form the independent investigative agency takes, "it should avoid adopting any procedures that would involve treating police witnesses any differently from the way lay witnesses are treated in criminal investigations" (p. 83).

f. The RCMP as an alternative to municipal police investigations

Given that the RCMP polices 70 percent of British Columbia's population and has the largest police force in the province, it would seem to make sense to assign police-related death investigations to that force, as an alternative to using other municipal forces. On the issue of independence, however, I question whether the level of public confidence would increase significantly if the criminal investigation of police-related deaths were assigned to the RCMP rather than to another municipal police department—it is still the police investigating themselves. Though the RCMP has a well-earned reputation for competence in serious crime investigations, and though it has the capacity to respond immediately and has access to specialized services, I have deep reservations about making such a recommendation.

In recommending that such criminal investigations be assigned to the RCMP, I would be recommending a new system in which a major component would be a police force over which the province has no significant supervisory authority. The province has no constitutional jurisdiction over the RCMP's internal management and administration, because it is regulated federally. When it comes to the professional conduct of RCMP officers, the provincial regime for making complaints (to police chiefs) and for overseeing the complaints process (by the provincial Police Complaint Commissioner) does not apply—professional standards complaints against RCMP officers are handled by the RCMP itself, and by the federal Commission for Public Complaints against the RCMP, based in Ottawa.

In his seminal 1994 report on policing in British Columbia, then-Justice Wally Oppal discussed at length the province's relationship with the RCMP, the contractual arrangements between them and the relevant court decisions. He concluded at page B-28:

> There is, of course, a compelling constitutional reason for the contractual ambiguity in these federal/provincial agreements. A series of Supreme Court of Canada decisions has seriously undermined the capacity of any provincial government to inquire into policing in areas policed by the RCMP and, by extension, to superintend policing services contracted to the RCMP.
>
> These decisions make it clear that the province has no constitutional authority to interfere with the internal management and administration of the RCMP. This limitation undermines the attorney general's ability to govern policing in areas policed by the RCMP....

Given the sensitive nature of criminal investigations into police-related deaths and the compelling need for accountability of those who conduct them, it would be illogical to recommend that some or all of them be assigned to a policing body over which the province has no supervisory authority.

3. Proposal for a civilian-based investigation model for British Columbia

From my review of the various options available, I have reached several conclusions.

First, I am satisfied that a home police department should not conduct criminal investigations of police-related deaths.

Second, I do not think that assigning such investigations to another municipal police department (one step removed) is an adequate response to the public's concern about the police investigating themselves. Given the disparate sizes and geographical configuration of municipal police departments in Greater Victoria and the Lower Mainland, I also have concerns about some departments' capacity and expertise to conduct such investigations. Neither do I support assigning such investigations to the RCMP, given the fact that the provincial government has no supervisory authority over that force.

Third, I do not think that assigning such investigations to a police-based investigation team (two steps removed) would be a significant improvement, because of similar concerns respecting independence, staffing and expertise.

Fourth, I am satisfied that a civilian-based investigation team model eliminates concerns about conflict of interest and, with adequate resourcing, can conduct competent criminal investigations. Although the situation in British Columbia is significantly different from that in Ontario, we can learn much from SIU's growing pains. I am impressed with Mr. Adams's conclusion in his 2003 report, quoted earlier, that "all police and community representatives framed their proposals as intended to improve the SIU, not to replace it."

Fifth, assigning criminal investigations of police-related deaths to an independent civilian agency serves the long-term interests of police officers. They would no longer be faced with allegations, however unfounded in individual cases, that conflict of interest influenced the investigation.

For all these reasons, I am satisfied that British Columbia should develop a civilian-based criminal investigation model for the investigation of police-related deaths occurring in the municipalities policed by the 11 municipal police departments. I turn now to a discussion of the essential features of this new model.

a. Mandate

Earlier in this part I discussed whether my recommendations should extend to serious injuries as well as deaths. I stated:

> I have decided not to include the investigation of police-related serious injuries in my recommendations for several reasons. First, the fact pattern that was before me involved a police-related death. I concluded that conflict of interest probably contributed to an unsatisfactory criminal investigation in that case, and I am willing to extrapolate from that incident the existence of a risk that conflict of interest will taint other police-related death investigations. However, without a firmer evidentiary basis, it would be imprudent for me to extrapolate any further, to cases of serious injuries.
>
> Second, while I am confident that a new system is required and should be established for all municipal police departments without delay, there is merit in proceeding incrementally when it comes to defining the mandate of this new system. Prudence suggests that we begin with the most serious category of cases first; then, after developing policies and practices, and gaining valuable on the ground experience, decide on whether the mandate should be broadened and, if so, how much.

For these reasons, I am recommending that, at least initially, the mandate extend only to police-related deaths. In my view, the term "police-related death" should be interpreted expansively, to include a wide variety of factual circumstances including (but not limited to) a death in a police department jail cell, a death resulting from an officer's use of force or a motor vehicle, or a death arising from some other form of police interaction with the deceased (such as in the Frank Paul case). Nevertheless, the important question of providing a sufficient volume of work for an organization that would conduct criminal investigations of all police-related deaths should be addressed in detail, and the mandate could be expanded to ensure an efficient and well-motivated office.

b. The name of the organization

Every new organization needs a name. While I do not have strong views on what this new organization should be called I will, for convenience, use the name Independent Investigation Office (IIO) in this report.

c. Accountability to civilian authority

While the IIO needs to be independent from the 11 municipal police departments, it should be accountable to civilian authority. The two options are to make the IIO an officer of the Legislature (similar to the Ombudsman, the Chief Electoral Officer and the PCC), or make the IIO accountable to a ministry within the Executive Branch, in which case the two most appropriate ministries to consider would be the Ministry of Public Safety and Solicitor General, or the Ministry of Attorney General.

Officers of the Legislature are created when there is a concern that the Executive Branch, by definition partisan, cannot impartially deliver (or oversee) the public service under consideration. The regulation and administration of provincial elections is an example, where the Chief Electoral Officer is accountable to the Legislative Assembly.

I am not persuaded that the IIO would need to be an officer of the Legislature, as the Executive Branch has no obvious partisan interest in the criminal investigation of police-related deaths.

I would recommend that the Ministry of Attorney General be the overseeing ministry. It would enhance the IIO's independence by being separate from the ministry that is responsible for superintending municipal policing.

d. The director

In my view the IIO director should have a background and experience that will command public respect and support for the office's independence, impartiality and competence. A current or former police officer should not be eligible for appointment. The director should be appointed by order-in-council for a fixed term of five or six years.

e. Statutory authority

To ensure the IIO's unquestioned authority to act, certain powers should be entrenched in legislation, such as:

- the IIO director and investigators have the status of peace officers,
- the chief constable of the jurisdiction in which a police-related death occurs must immediately advise the IIO of the incident,
- pending arrival of the IIO at the incident scene, the chief constable must ensure that the scene is secured, that officers involved in the incident are segregated from each other and that evidence is preserved,
- officers involved in the incident must not communicate with each other about the incident, except as authorized by the IIO,
- the IIO becomes the lead investigative agency, and the home police department has no investigative responsibility or authority, except as granted by IIO,
- a witness officer must promptly make himself or herself available for an interview with the IIO investigator, and must promptly deliver to the IIO all notes, reports and other investigative materials relevant to the incident, and
- a respondent officer may be—but is not compelled to be—interviewed by the IIO, but must in all cases promptly deliver to the IIO all notes, reports and other investigative materials relevant to the incident.

f. Organizational structure and staffing

Decisions about organizational structure will be influenced by the overall number of investigations to be conducted annually, and the municipalities in which the police-related deaths occur.

According to the SIU's *Annual Report 2005–2006*, 39 of the 204 incidents investigated (or about 20 percent) were in relation to deaths rather than serious injuries. Given that Ontario's SIU has province-wide jurisdiction (and a total population of 12 million), but that British Columbia's proposed IIO would operate in only 11 municipalities (with a total population of 1.1 million), we can estimate that the IIO would have approximately 10 percent as many death investigations as the SIU, or about four to five annually.

A comparable number is reached by examining the number of in-custody and police-related deaths reported by the BC Coroners Service. In the seven-year period between 2000 and 2006, the municipalities policed by municipal police departments had the following number of in-custody/police-related deaths (Table 2):

Table 2: Number of in-custody/police-involved deaths, 2000–2006[425]

Region	Municipality	2006	2005	2004	2003	2002	2001	2000	Total
Greater Victoria	Victoria (incl. Esquimalt)	2	0	3	0	1	0	2	**8**
	Saanich	0	0	0	0	0	0	0	**0**
	Oak Bay	0	0	0	0	0	0	0	**0**
	Central Saanich	0	0	0	0	0	0	0	**0**
Lower Mainland	Vancouver	2	1	5	5	5	2	5	**25**
	West Vancouver	0	0	0	0	0	0	0	**0**
	Delta	0	0	0	0	0	1	0	**1**
	New Westminster	1	0	1	1	0	0	0	**3**
	Port Moody	0	0	0	1	0	0	0	**1**
	Abbotsford	1	0	1	0	0	0	0	**2**
Kootenays	Nelson	0	0	0	0	1	0	0	**1**
Total		**6**	**1**	**10**	**7**	**7**	**3**	**7**	**41**

According to this data, there were 41 in-custody/police-related deaths in municipal police jurisdictions over seven years, for an annual average of six, although the number of incidents varied between one and 10 per year. Eighty percent occurred in the Lower Mainland, with nearly two-thirds occurring in the city of Vancouver.

Based on this analysis, it would be logical to locate the IIO headquarters within or near Vancouver.

[425] Source: Office of the Chief Coroner, BC Coroners Service, as published in http://www.straight.com/article-119352/nurse-troubled-by-tasers?

g. Charge recommendation

The director will recommend whether criminal charges should be laid. Where charges are recommended, the director should set out which officer or officers should be charged, and give specifics as to the criminal offence and the particulars of the offence.

The question of whether the director should be the one to approve criminal charges—rather than Crown Counsel—is an important one. I understand this to be the practice in Ontario, although I appreciate that in Ontario (as in most provinces), the police determine who is charged criminally—while in BC that determination is left to Crown Counsel. Because I have not had input on this issue from the Criminal Justice Branch, I may reconsider this recommendation if, at the conclusion of the litigation involving the branch, further information persuades me that a different approach is necessary. I reserve the right to consider, for instance, whether the IIO director should approve criminal charges, and also to what extent special prosecutors should be employed in such cases.

h. Civilian oversight

In Ontario, the provincial Ombudsman has jurisdiction over the SIU. I recommend a similar provision in British Columbia.

i. Cost and funding of the IIO

In Ontario, the annual cost of operating the SIU (which serves a population of 12 million) is approximately $5.5 million. The proposed IIO will serve a population of approximately 1.1 million, so the annual cost would be a fraction of the Ontario cost. How should it be funded?

One of the most valuable lessons to be learned from the Ontario experience is that the competence and credibility of the IIO will be contingent on adequate funding.

There are two alternatives. Municipal police departments could contribute to the cost of the IIO on a per capita basis, or could be charged back based on the proportion of the IIO's time spent investigating incidents arising within their jurisdictions. Alternatively, the province

could absorb the cost of the IIO, on the basis that it is removing this responsibility from the police departments and assigning it to a provincially mandated body overseen by the province. There is some precedent for the latter option, in that the province funds the PCC, which oversees the manner in which municipal police departments deal with professional standards complaints. On balance, it would appear preferable that the province assume responsibility for funding the IIO. Given the limited amount of financial and limited information available to me as Commissioner, I do not make this as a formal recommendation.

G. Recommendations

4. I recommend that British Columbia develop a civilian-based criminal investigation model for the investigation of police-related deaths occurring in the municipalities policed by the 11 municipal police departments.

5. I recommend that the initial mandate of this organization (which I suggest be named the Independent Investigation Office (IIO)) include a wide variety of factual circumstances, including (but not limited to) a death in a police department jail cell, a death resulting from an officer's use of force or a motor vehicle, or a death arising from some other form of police interaction with the deceased.

6. I recommend that the IIO be accountable to the Ministry of Attorney General.

7. I recommend that the IIO be led by a director appointed by Order in Council for a fixed term of five or six years.

8. To ensure the IIO's unquestioned authority to act, I recommend that its essential powers be entrenched in legislation, such as:

- **the IIO director and investigators have the status of peace officers,**
- **the chief constable of the jurisdiction in which a police-related death occurs must immediately advise the IIO of the incident,**

- **pending arrival of the IIO at the incident scene, the chief constable must ensure that the scene is secured and that officers involved in the incident are segregated from each other,**

- **officers involved in the incident must not communicate with each other about the incident, except as authorized by the IIO,**

- **the IIO becomes the lead investigative agency, and the home police department has no investigative responsibility or authority, except as granted by IIO,**

- **a witness officer must promptly make himself or herself available for an interview with the IIO investigator, and must promptly deliver to the IIO all notes, reports and other investigative materials relevant to the incident, and**

- **a respondent officer may be—but is not compelled to be—interviewed by the IIO, and must in all cases promptly deliver to the IIO all notes, reports and other investigative materials relevant to the incident.**

9. **I recommend that the director recommends to the Criminal Justice Branch whether criminal charges should be laid, and if so, which charges, involving which officer or officers.**

10. **I recommend that the provincial Ombudsman have jurisdiction over the IIO.**

PART 7—THE PROFESSIONAL STANDARDS INVESTIGATION OF POLICE-RELATED DEATHS

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PART 7—THE PROFESSIONAL STANDARDS INVESTIGATION OF POLICE-RELATED DEATHS

A. Introduction

When a police-related death occurs, two types of police investigations may result. The first is a criminal investigation, to ascertain whether a police officer's action or inaction constitutes a criminal offence. I discussed this type of investigation in Part 6 of this report.

The second type of investigation that may result from a police-related death is a professional standards investigation, to ascertain whether a police officer's action or inaction constituted a breach of a professional duty. If such a breach is established, the officer will face internal disciplinary proceedings.

A professional standards investigation happened in the Frank Paul case, which I summarized in Part 4 of this report. In the pages ahead I will examine more broadly the legislative scheme for conducting professional standards investigations, beginning with the recommendations made by then-Justice Wally Oppal in his 1994 *Policing in British Columbia* about the handling of complaints against police officers. I will then outline the role of police departments in professional standards investigations, and the oversight role of the PCC, as set out in Part 9 of the *Police Act*.

B. 1994 *Policing in British Columbia* (Oppal Report)[426]

This report addressed a wide range of policing issues, including governance, community-based policing, regionalization of policing services, Aboriginal policing, and complaints and discipline.

The 81-page chapter dealing with complaints and discipline involved an exhaustive analysis of all aspects of these issues. Justice Oppal's fundamental decision was to recommend that the existing system whereby the police investigate themselves be continued, subject to a more robust form of external civilian oversight through a proposed new complaint commissioner. He reported that many stakeholders had stressed the need to find an appropriate balance between police self-regulation and external oversight, and then stated his own conclusion that:

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[426] The full title is *Closing the Gap: Policing and the Community, Policing in British Columbia*. It is variously known as *The Oppal Report* and *Policing in British Columbia*.

> There must be a strong element of civilian oversight in the public complaints process in order to safeguard the public perception that the process is legitimate (p. I-2).

Having made that fundamental decision, he then turned to the three civilian oversight models that had been discussed, ranging from strongest to weakest oversight:

- **Civilian oversight**—which places the authority to investigate, adjudicate and recommend discipline with an external agency,

- **Civilian input**—which places only reception and investigation of complaints with an external body, while adjudication and punishment remain with the police department, and

- **Civilian monitor**—which leaves investigation, adjudication and discipline with the police department, while civilians review the adequacy and impartiality of these procedures.

After discussing the extent to which there should be police involvement in investigations,[427] Justice Oppal recommended a model that incorporated some elements of the second and third options. Although the police would continue to investigate themselves, his proposed complaint commissioner would have significant authority to intervene in police investigations of complaints, including the following:

- actively supervise investigations of complaints with cooperation from police investigators,

- conduct an investigation,

- require investigating officers to justify particular lines of questioning, interview additional witnesses, consult experts, gather other kinds of data or evidence, and account for their conclusions, and

- assume conduct of an investigation initially or while an investigation is in progress, using independent investigators or police from any agency, or both (p. I-28).

As I will discuss below, these proposals for an activist police complaint commissioner did not find their way into the 1998 *Police Act*.

[427] Ibid., pp. I-24 and I-25.

C. The 1998 *Police Act*

After three years of consultations and negotiations with the various stakeholders, a new *Police Act* was enacted in 1997,[428] and brought into force on July 1, 1998. The Act preserved the "police investigating themselves" model, and established a new police complaint commissioner (PCC), who is an independent officer of the Legislature.

1. Part 9 of the *Police Act*

Part 9 deals with police complaints and disciplinary measures, including the PCC. It is fundamentally a complaint-driven system. When a complaint is made (either to the police department or to the PCC), the police department must promptly characterize the complaint as a public interest complaint, an internal discipline complaint, or a service or policy complaint (s. 52.1(1)). The PCC must, within 10 days, review that characterization and either confirm it or overrule it, and independently characterize it (s. 52.1(6)).

a. *A public trust complaint* refers to conduct that constitutes a breach of the *Code of Professional Conduct Regulation*,[429] and that does one of the following:

- causes or has the potential to cause physical or emotional harm or financial loss to any person,
- violates any person's dignity, privacy or other rights recognized by law, or
- is likely to undermine public confidence in the police.

b. *An internal discipline complaint* means a complaint that relates to the acts, omissions or deportment of a police officer that does not constitute a public trust complaint. It may also include a public trust complaint that is not processed as a public trust complaint. This type of complaint is normally dealt with under the collective agreement's grievance procedure (s. 64).

c. *A service or policy complaint* means a complaint to the effect that a police department's policies, procedures, supervision and management controls, training programs, staffing or resource allocations are inadequate or inappropriate. This type of

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[428] S.B.C. 1997, c. 36.

[429] See *Code of Professional Conduct Regulation*, BC Reg. 205/98, available at: http://www.qp.gov.bc.ca/statreg/reg/P/Police/205_98.htm. The code creates "disciplinary defaults" for matters such as discreditable conduct, neglect of duty, deceit, improper disclosure of information, corrupt practice, abuse of authority, and improper use and care of firearms.

complaint is dealt with by the police board, which may initiate a study or an investigation. The PCC oversees the board's handling of such complaints (s. 63.1).

2. Processing a public trust complaint

In the Frank Paul case the complaint was characterized as a public trust complaint, and the discussion that follows will be limited to a description of the process applicable to those types of complaints.

Under s. 54.1 of the *Police Act*, a complaint may be resolved informally if the discipline authority (i.e., the chief constable or his or her delegate) considers that disposition to be appropriate, and if the officer and the complainant consent.

In all other cases, the discipline authority must initiate an investigation into a public trust complaint (s. 55). The PCC may appoint an employee of that office as an observer to the investigation, if the PCC considers the appointment necessary in the public interest (s. 56.1(1)). An investigation must normally be completed within six months (s. 56(7)), but the PCC may grant an extension. Within 10 days of receiving the final investigation report, the discipline authority must:

- provide a summary of that report to the officer and the complainant, and a complete, unedited copy of the final investigation report to the PCC (s. 57), and

- determine whether the evidence is sufficient to warrant the imposition of disciplinary or corrective measures (s. 57.1). If the discipline authority determines that disciplinary or corrective measures are warranted, the discipline authority must notify the respondent and complainant, identifying the alleged discipline defaults, whether a pre-hearing conference will be offered, and a description of the response proposed by the discipline authority to each alleged default.

a. The pre-hearing conference

Under s. 58, the disciplinary authority may proceed—by way of a confidential, without prejudice, pre-hearing conference—to determine whether the officer is willing to admit a public trust default and, if so, what disciplinary measures the officer is willing to accept. However, this procedure must not be offered if the complaint is sufficiently serious to warrant dismissal or reduction in rank, or if a pre-hearing conference would be contrary to the public interest. If the

disciplinary or corrective measures are accepted by the officer and approved by the disciplinary authority, the complainant must be notified. A complainant who is aggrieved may file with the PCC a request for a public hearing.

b. The discipline proceeding

If a public trust complaint is not resolved at a pre-hearing conference, a discipline proceeding must be convened (s. 58.1). The officer, the investigating officer and the discipline authority must attend a discipline proceeding, and the only other people who may attend are the PCC and the officer's counsel. According to s. 59(2), the only witness at a discipline proceeding is the investigating officer. The officer (i.e., respondent) is not compellable, but may ask questions of the investigating officer and may make submissions. However, it seems clear that the officer also may testify because, according to s. 61.1(1), an adverse inference may be drawn if the officer fails to testify. The discipline authority must decide whether a discipline default has been proved on the civil standard of proof and, if so, decide within 10 days on appropriate disciplinary or corrective measures (s. 59).

c. A public hearing

Under s. 59.1, the PCC must be provided with the entire unedited record of the discipline proceeding. Under s. 60, the commissioner may order a public hearing if he or she considers that necessary in the public interest. If the officer requests a public hearing, the commissioner must order one if the disciplinary or corrective measure imposed was more severe than a verbal reprimand. The officer is not compellable at a public hearing, but an adverse inference may be drawn from the officer's failure to testify. The adjudicator at a public hearing may find that all, part or none of the alleged discipline default has been proved, impose any disciplinary or corrective measures that a disciplinary authority may impose, or affirm, increase or reduce any such measures (s. 61).

D. The PCC's Authority to Intervene in a Police Department's Professional Standards Investigation

Part 9 of the 1998 *Police Act* also gives the PCC specific authority to intervene in a police department's professional standards investigation in three circumstances that may be relevant to this inquiry:

- s. 55(3)—Despite any other provision of the Act, the police complaint commissioner may order an investigation into the conduct of a police officer (or a chief or deputy chief constable), whether or not a record of complaint has been filed. The commissioner may appoint an employee of that office as an observer to the investigation, if the commissioner considers the appointment necessary in the public interest (s. 56.1(1));

- s. 55.1—the police complaint commissioner may refer an investigation of a public trust complaint to another municipal police department or to the RCMP, if the commissioner considers that an external investigation is necessary in the public interest; and

- s. 56.1—if the police complaint commissioner concludes that the original investigation was inadequate or unreasonably delayed, he or she may:

    - order a new investigation (i.e., by the same police department), or
    - order an investigation by another municipal police department or by the RCMP, and
    - the commissioner may appoint an employee of that office as an observer to the investigation, if the commissioner considers the appointment necessary in the public interest.

E. The Professional Standards Investigation in the Frank Paul Case

Earlier in this report (see Part 4), I summarized the evidence I heard during the Phase 2 evidentiary hearings respecting the VPD's internal (now called professional standards) investigation arising out of Mr. Paul's death. In brief, Andrew Hobbs, then a sergeant in the department's Internal Investigations Section (later renamed the Professional Standards Section) was assigned the Frank Paul file in May 1999.

After reviewing Det. Staunton's 130-page criminal investigation file, Sgt. Hobbs concluded that there were public trust issues arising out of this very serious case that should be investigated under the *Police Act*, given the fact that someone who had been in police custody had been released into an alley, dying shortly thereafter.

On August 3, 1999, Sgt. Hobbs completed a Form 1 complaint document, and forwarded a copy to the PCC. In September 1999, he was transferred out of the Internal Investigation Section, and the Frank Paul file was assigned to Sgt. Donald Boutin.

Sgt. Boutin testified that in normal professional standards cases, when a member of the public makes a complaint about a police officer's conduct, the investigating officer interviews the complainant; or obtains a written duty report from the respondent officer; reviews other documentation; and then prepares a report for the inspector in charge of the section.

However, the procedure is different in cases where there has been a Major Crimes criminal investigation, such as the Frank Paul case. The professional standards investigator relies primarily on the homicide investigator's written report to Crown Counsel, as Sgt. Boutin did in the Frank Paul case. He testified that the assumption would be that the homicide investigation was comprehensive, and consequently it would normally be unnecessary to do any additional investigation. He did, however, take some investigative steps in the Frank Paul case, such as attempting to obtain a duty report from one of the officers, and obtaining information about the weather on the night of Mr. Paul's death. He did not interview Sgt. Sanderson or Cst. Instant—he relied on their written reports. The practice is that the professional standards investigation does not proceed until Crown Counsel decides whether criminal charges will be laid, and until the coroner decides whether an inquest will be held. In the event of either or both of those proceedings, the professional standards investigator would await their conclusion, and would include in his analysis the evidence tendered during those proceedings.

At one stage during Sgt. Boutin's investigation there were discussions within the section about resolving the investigation by way of "management advice," an informal disposition procedure used by the VPD that was outside the possible dispositions set out in Part 9 of the *Police Act*. He did not think this was an appropriate disposition, and ultimately recommended two-day and one-day suspensions without pay. Insp. Eldridge and the chief constable approved his recommendations. After the disciplinary measures were imposed, Sgt. Boutin forwarded the professional standards file to the PCC, who ultimately decided not to order a public hearing.

F. The Vancouver Police Department's Current Practice

Although I did not hear testimony during the evidentiary hearings about the VPD's current policies and practices respecting professional standards investigations, such

investigations are governed by the legislative requirements of Part 9 of the *Police Act*, as supplemented by the department's manual.[430]

1. When an officer's action results in death or serious injury

Section 3.1 of the manual sets out the Professional Standards Section's obligations when a death or serious injury results from an officer's action, regardless of whether a Form 1 complaint has been lodged under the *Police Act*. In every such case:

- The Duty Officer shall notify the officer-in-charge of the Professional Standards Section of the death or serious injury as soon as possible, who will arrange for the appropriate response.
- A Professional Standards Section investigator will be assigned.
- An order to investigate will be sought in all such incidents where examination of the initial evidence indicates a possible breach of a disciplinary breach.
- The investigator may consider suspending the *Police Act* investigation until conclusion of the criminal investigation.
- An investigator will be assigned to review the final report of the Major Crime Section investigators, and to review the file for any policy breaches or training concerns.
- The investigator will submit his or her final report, with findings and recommendations, to the officer-in-charge.
- The officer-in-charge may, out of professional courtesy, share the investigator's report with the PCC.

2. In response to a Form 1 complaint

When the VPD receives a Form 1 complaint about an officer's conduct, the manual's provisions largely repeat the procedures mandated by Part 9 of the *Police Act*.

However, when a Form 1 complaint contains a criminal allegation, then the criminal investigation must take place first and, if it appears that this

[430] See http://vancouver.ca/police/ProfessionalStandards/Documents/Policy_Manual.pdf.

investigation will take longer than six months, the Professional Standards Section should consider applying to the PCC for a suspension of the usual six-month time limit.

Once the criminal investigation is completed, that investigation is to be discussed with the officer-in-charge of the Professional Standards Section and the chief constable. If the evidence supports a charge, or if it is in the best interest of transparency, the file is to be sent to Regional Crown Counsel for review.[431] Any professional standards investigation is to be postponed, pending completion of criminal proceedings against the officer, if criminal proceedings are instituted.

Section 3.6 of the manual identifies two situations in which a police officer conducting a professional standards investigation should apply to the PCC for an order to commence a *Police Act* investigation, even if no complainant steps forward with a Form 1 complaint:

- when the officer receives information alleging that another officer committed, on or off duty, a serious disciplinary default, or
- any incident where the actions of an officer contributed to a death or serious injury.

In such cases, the manual stipulates that the officer should not complete a Form 1.

G. Recent Calls for Reform in British Columbia

Since Part 9 of the *Police Act* came into force in 1998, it has been the subject of several reviews, leading to proposals for reform, to which I now turn.

1. The Legislative Assembly's special committee

Section 51.2 of the *Police Act* requires that a special committee of the Legislative Assembly begin a comprehensive review of Part 9, and the work of the PCC, within three years of Part 9 coming into force.

[431] There appears to be a conflict between this provision and the department's practice, as testified to during the evidentiary hearings. My understanding of the testimony of several officers during the evidentiary hearings is that in every police-related death, the officer in charge of the criminal investigation forwards his or her "neutral" Report to Crown Counsel, without making a recommendation whether criminal charges should be laid. However, this provision of the manual states that the officer should send the Report to Crown Counsel only "if the evidence supports a charge...."

The special committee was established in August 2001. In its August 2002 report,[432] the committee reported that it had heard from 68 witnesses, had received 28 additional written submissions, and had sent (through the PCC) a questionnaire to 1,043 individual complainants, of whom 268 responded.

The special committee reported that:

> A general consensus exists that the police complaint process, as established, is a good one—held out as a model for other jurisdictions around the world. The Committee recognizes that many of the issues identified by witnesses in fact concerned the implementation and application of the Act, rather than the legislation itself (pp. 5–6).

Four main themes emerged from the committee's public consultations:

- the need to improve public confidence in the complaint process,
- the need to improve the informal resolution process and to use that process more frequently,
- the need for procedural improvements to enhance the fairness of the complaint process for complainants and respondents, and
- the need to clarify the role of the PCC.

The special committee made 20 recommendations for amendments to Part 9, and 22 other recommendations. The recommendations that are most relevant to this analysis include the following:

- 5: that a special committee review Part 9, and the work of the Police Complaint Commission, not less than every four years.
- 8: the special committee concluded that s. 55(3) was intended "to allow the Commissioner to intervene in exceptional circumstances that may occur, such as a police 'cover up' of a significant public interest matter." It agreed that the police complaint commissioner "should function primarily as an oversight agent, but that he or she should have adequate discretionary powers to ensure that the police complaint process satisfies the objective of providing police accountability to the public" (pp. 14–15). The special committee recommended that s. 55(3) should be amended as follows:

[432] *Special Committee to Review the Police Complaint Process, Second Report*, August 2002. See http://www.leg.bc.ca/cmt/37thparl/session-3/pcp/reports/aug2002.htm.

> Despite any other provision of this Act, the Police Complaint Commissioner may inquire into the conduct of a municipal constable, chief constable or deputy chief constable, and may order an investigation whether or not a record of complaint has been lodged.

- 25: that the provisions already contained in s. 54.1 to consider informal resolution processes for public trust complaints be used more frequently.

- 27: that the Police Complaint Commissioner be mandated to encourage informal resolution and mediation.

The Legislative Assembly has not yet acted on any of those proposed amendments.

2. The Police Complaint Commissioner's White Paper

In his *2003 Annual Report*, Commissioner Ryneveld called for urgent reform of the *Police Act*. He renewed that call in his subsequent report on the RCMP's external investigation of complaints brought forward by the Pivot Legal Society against members of the VPD. He was particularly concerned that the legislation should impose a duty on police officers to cooperate with investigations, if the civilian oversight process is to retain its legitimacy and credibility.

He formalized those proposals in his June 2005 White Paper,[433] in which he suggested reforms to the *Police Act*, and appended a draft *Police Complaint Act* which would replace Part 9 as a freestanding statute, to emphasize the separation between his office and other aspects of provincial regulation of municipal policing.

He set out the four fundamental principles that underlay his proposed reforms:

Civilian oversight
Free and democratic societies must have effective civilian oversight processes for addressing allegations of individual or systemic breaches of proper police conduct.

[433] See http://www.opcc.bc.ca/Reports/2005/White%20Paper%20Final%20Draft.pdf.

Legislative foundation

The police complaint commissioner needs a sound legislative foundation that enables the civilian overseer to effectively carry out his or her functions.

Structural independence of the police complaint commissioner

After affirming the vital need for the commissioner to be structurally independent from the Executive Branch, he added:

> Second, as necessarily implicit in Justice Oppal's recommendations, a Commissioner perceived to be subject to political influence in the method of his appointment, dismissal and resource allocation would lose legitimacy and credibility in the eyes of reasonable members of the public. This would undermine the entire statute. British Columbia would otherwise have to seriously consider turning to the Ontario model of a Special Investigation Unit. This is why, for Justice Oppal, the Commissioner's independence as an officer of the legislature was the *quid pro quo* for even allowing police to investigate themselves (p. 6).

Regulatory process

The police complaint process is not a criminal or quasi-judicial process in which an officer is charged, on trial and subject to a criminal proceeding. Rather, it is a regulatory disciplinary process, from which it follows that Part 9 should properly reflect the structures and features of modern regulatory statutes. This includes a duty on respondent officers to cooperate fully with investigating officers.

His recommendations that are most relevant to this inquiry include the following:

- S. 9: binding directives would address matters ranging from the duties of persons receiving complaints to the protocols, practices and procedures to be followed by investigating officers in conjunction with the collection of evidence or the taking of statements of witness officers and respondent officers. He added a telling footnote:

  > For example, on this issue most members of the public would likely assume that when a serious incident takes place in which a police officer causes death or serious injury to a civilian, protocols are in place akin to those in regular investigations, whereby the officer is questioned promptly, and steps are taken to avoid advertent or inadvertent collaboration between officers present at the scene. However, the experience of this office has been that on too many occasions, protocols on such basic investigative matters are either lacking or not followed.

- S. 9: like the existing power that the police complaint commissioner has to order an external investigation, he recommended that there be a similar power to replace the disciplinary authority (i.e., at the adjudicative stage) with an external disciplinary authority, in exceptional circumstances. This power is designed "to be exercised with restraint, and to address situations where a disciplinary authority, by his or her actions, statements or connections with an individual, is reasonably perceived as being incapable of making a fair and impartial decision" (p. 12).

- S. 25: he recommended continuation of the current provisions respecting external investigations, but added the following commentary:

  > A significant question arising during my deliberations has been whether to recommend that this Office receive the power in exceptional circumstances to conduct independent investigations. Such a power was recommended in the Oppal Commission Report, reinforced in Justice Oppal's testimony before the Special Committee, acknowledged as a legitimate option by at least one municipal police chief [Victoria] before the Special Committee and proposed by me in my last Annual Report.
  >
  > I have over the past year had further opportunity to reflect on this question, and in this context I have considered the responsiveness and the quality of the external investigations I have ordered under s. 55.1 of the Act. I can state without hesitation that I have been extremely satisfied with the responsiveness, expertise and quality of the external investigations conducted to date. This informs my present view that, on balance, my Office does not need an independent power to investigate if the legislation is amended to:
  >
  > - create a formal duty in police officers to cooperate with internal and external investigators, and
  > - reinforce the duty of police departments and the provincial police force [i.e., the RCMP] to conduct external investigations when ordered.

3. The Police Complaint Commissioner's Green Paper

In August 2006, in response to reaction to his White Paper, the PCC published a Green Paper entitled *Reform of the Police Complaint Process: Supplementary Report of the Police Complaint Commissioner*.[434] While he affirmed most of his earlier recommendations, he reconsidered his position respecting whether the

[434] See http://www.opcc.bc.ca/Reports/2006/GreenPaper4.pdf.

commissioner should be granted an independent power to investigate complaints. He noted that Justice Oppal had recommended such a power in 1994, but it had been excluded when the *Police Act* was enacted in 1998, in favour of the PCC's powers to order external investigations and to order new investigations.

The PCC summarized the opposing views on the issue:

- The police chiefs stated that such a power would damage the public's confidence in the police, and that "the legislature should be wary of the inadvertent creation of a quasi-investigational body in the Office of the PCC.... Such a shift in philosophy, it is submitted, requires a much broader public policy debate."

- The BC Civil Liberties Association stated that a home police force should never be allowed to investigate police misconduct, particularly in cases involving deaths or critical injuries involving a member of that force. In the case of a death or serious injury of a civilian in police custody, there should always be an independent civilian-led investigation. The PCC should have the discretion to independently investigate a matter where he or she considers there is good reason to do so. An independent investigation power would:

    - Increase public confidence in the complaint process,
    - Act as an incentive for the police to be thorough in their internal investigations,
    - Act as a safeguard where both an internal and external investigation are unsatisfactory,
    - Increase the confidence of complainants in making complaints, and
    - Provide a power that is not dependent on the personalities of the particular individuals who happen to run internal investigation departments.

The PCC concluded that the time had come for the professional standards investigations of death and serious injury cases to be conducted by an agency other than the home police force. The options included:

- An external police force,

- A specialized unit of police officers drawn from municipal police departments and the RCMP, dedicated to independent *Police Act* investigations, or

- The Office of the Police Complaint Commissioner.

While he expressed satisfaction with the quality of past external investigations, he recognized that they sometimes result in financial and personnel hardships for some police departments.

On the other hand, a specialized and integrated unit of police officers, involving specially trained officers acting at arm's length from any particular police department, with a measure of financial contribution from the province, had much to commend it in both principle and practice. He was satisfied that the legislation could easily be crafted to make such a unit automatically responsible for death and critical injury investigations. It could also be activated in other cases, at the instance of the PCC.

He concluded as follows:

> If the creation of such a unit is not deemed practicable, the responsibility should fall upon my office, in a fashion akin to what has been proposed for Ontario under Bill 103[435] which was drafted as a result of the *LeSage Report* (April 2005). Consistent with that responsibility, provisions will have to be added to the statute ensuring that the Commissioner is in a position to retain a proper team of investigators, and is armed with necessary investigative powers.

4. The 2007 Josiah Wood Report

In July 2005, the director of the Police Services Division of the provincial Ministry of Public Safety and Solicitor General appointed former Justice Josiah Wood to address the shortcomings in Part 9 of the *Police Act*, and to make recommendations for improvement. In February 2007, he submitted his report entitled *Report on the Review of the Police Complaint Process in British Columbia*,[436] which included 91 recommendations.

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[435] See *An Act to establish an Independent Police Review Director and create a new public complaints process by amending the Police Services Act*, Bill 103, 2006.
[436] See http://www.pssg.gov.bc.ca/police_services/publications/.

I will now discuss the process Mr. Wood followed, as well as his findings, then summarize his consideration of alternatives to a home police department conducting professional standards investigations, particularly in cases of police-related deaths.

a. Process

His study included three surveys and two audits:

- A public awareness survey of 1,024 residents of the 11 municipalities served by municipal police departments,
- A core area awareness survey of residents of Vancouver, New Westminster and Victoria,
- A police awareness survey of all 2,245 sworn members of the 11 municipal police departments,
- An administrative audit on a randomly selected sample of 294 lodged complaint files that were closed between June 2003 and June 2005, and
- An investigative audit of those same 294 closed files.

Mr. Wood conducted 141 interviews with chief and deputy chief constables, other discipline authorities, professional standards officers, union representatives, the police complaint commissioner and his staff, and other interested parties. In addition, each of the respondents and complainants in the 294 randomly selected audit files were invited to participate in an interview, with an understanding that any information provided would be treated confidentially. He also reviewed police complaint processes in other Canadian jurisdictions, the work of the 2002 Select Committee and the police complaint commissioner's 2006 White Paper.

b. Findings

The investigative audit showed that 42 percent of the complaint files had investigative deficiencies. Although some of these were minor, 19 percent of the complaint files did not meet the reasonable and appropriate standard imposed by the investigative audit team. Since all but four of these files were serious abuse of authority complaints (e.g., excess force, wrongful search and wrongful arrest), he found these results to be

unacceptable, and they became the driving force behind many of his recommendations.

Mr. Wood's analysis began with recognition that in 1998, the Legislative Assembly adopted a police complaint model that left the responsibility for investigating complaints and imposing discipline for proven misconduct with the police, and provided for a civilian authority, independent of government, to oversee the discharge of those responsibilities. In his view, "the results of this review have not persuaded me that it is necessary at this time to change the basic structure of that model" (para. 33). However, he added:

> It became obvious early in this review, that the police complaint commissioner had few effective powers with which to ensure that all public complaints were thoroughly investigated and properly concluded. As will be discussed in greater detail later in the report, the power to order a further investigation by an external police department is a poor remedy for an initial investigation that is flawed, and the power to order a public hearing is an equally poor remedy for an erroneous disposition in the case of a complaint that does not raise issues that meet the high public interest standard required to justify engaging that seemingly complex, expensive and generally unsatisfactory process (para. 28).

Based on his analysis of these 294 files (none of which involved a police-related death), he concluded that: "there is an unacceptably high risk that the more serious public trust complaints will not either be investigated thoroughly or concluded appropriately" (para. 183).

c. Alternatives

Mr. Wood's principal concern related to the handling of serious public trust complaints. He considered three different alternatives to the current system under which the home police department conducts the professional standards investigation: a "seconded" investigative unit, an independent investigative unit, and a more active role for the police complaint commissioner:

A "seconded" investigative unit

This would consist of police officers drawn from existing municipal police departments, who would conduct what would amount to external investigations of serious public trust complaints. It would be quartered separately, have its own chain of command, and operate independently from any individual municipal police force. If properly equipped and resourced, Mr. Wood felt that such an investigative unit would have the potential to conduct investigations that would be (and appear to be) impartial, with greater consistency in quality and faster disposition rates. However, he concluded that this option was not viable at present, because of cost. Each police force would have to contribute officers to the unit, but would still need to maintain an in-house capacity to investigate less serious complaints. The unit would incur additional costs for separate facilities, equipment and administrative support staff, and relocation costs for some officers. There would be significant travel costs in relation to complaints arising out of the Greater Victoria police forces or, alternatively, establishment of a second facility in Victoria.

An independent investigation unit

This would be a stand-alone *civilian* entity, and would require a staff of between six and eight investigators, plus administrative staff, premises costs, and other operating and capital costs. Mr. Wood was not attracted to this model, because of similar cost concerns.

A more active role for the police complaint commissioner

Mr. Wood concluded that the results of the investigative audit did not justify removing from police departments the responsibility for *investigating* public trust complaints. A preferable approach would be to increase the *oversight* role of the Office of the Police Complaint Commissioner with respect to the investigation of

public trust complaints, without going so far as to make the commissioner responsible for actual conduct of such investigations. In his view, oversight needs to occur during, not after, the investigation, and it must be based on full access to the investigation as it unfolds. Consequently, the role of the police complaint commissioner should be expanded to provide that, at any time after receipt of a record of complaint:

- The commissioner may review the conduct of an ongoing investigation,
- Upon consultation with the investigating officer and/or discipline authority, the commissioner may provide such advice and/or direction as necessary to ensure that a full and thorough investigation is conducted,
- The commissioner must, on an ongoing basis and on request, be afforded full access to the investigative file and any other documents or information in the possession of the police force which may be relevant to that investigation, and
- The commissioner must have a specific statutory power to order an external investigation in those instances where the advice and/or direction given with respect to an ongoing investigation is not accepted and complied with by the investigator, and to require that the full investigative file be turned over to the new external investigator.

For these reforms to be effective, it would be necessary for all complaint files to be stored electronically, and for the OPCC to have ongoing electronic access to them. He recommended adoption of the Integrated Police Data Management Application (IPDMA) developed by the Saanich Police Department, with enhancements that would enable the Office of the Police Complaint Commissioner to access this database.

d. The investigation of in-custody and police-related deaths

Mr. Wood then directed his attention to circumstances in which a person dies in police custody or as a result of police-related actions (para. 219). There were no such cases among the 294 investigative audit files, so he resorted to BC Coroners Service statistics. Between 2002 and 2004, there were 26 in-custody or police-related deaths in the 11 municipal police

department jurisdictions. The PCC received only seven complaints arising out of these deaths, which were cases of police shootings (4), use of the Taser (2) and use of force during arrest (1).

Mr. Wood acknowledged that such deaths are the natural breeding ground for suspicion and distrust, but he was not persuaded "that this category of complaint gives rise to a compelling argument for the establishment of either of those specialized investigative units, particularly if there exists an alternative means by which the requisite degree of accountability can be achieved in such cases" (para. 223).

He recommended that the Act be amended as follows:

- The police complaint commissioner must be given notice of any in-custody or police-related death,
- An external investigation must be conducted in all in-custody or police-related deaths, whether or not a complaint has been lodged in connection with the death,
- All such investigations must be subject to the same contemporaneous oversight powers given to the police complaint commissioner in the case of other public trust complaints, and
- The scope of available external agencies should not be limited to an existing municipal police department or the RCMP (para. 232).

e. Concluding caution

Mr. Wood was clearly troubled by the policing community's resistance to more robust civilian oversight. In his "Conclusion," he effectively gave the policing community one last chance, by observing that arguments in favour of the police investigating complaints

> can prevail only so long as there exists a demonstrated willingness on the part of such management, and all who serve below, to fully accept the authority of civilian oversight. With that in mind and, if the recommendations contained in this report are implemented, I recommend that a further audit of a random sample of closed complaint files, similar to that which was conducted as part of this review, be undertaken three years following the date of such implementation, with a view to determining whether the Part 9

complaint process and civilian oversight model should be retained in this province (para. 353).

5. Summary of proposed reforms in British Columbia

It might be useful to summarize how the issue of the professional standards investigations of police conduct has been considered in British Columbia since the early 1990s, in reports and in legislation:

- In 1994, then-Justice Oppal recommended that police departments continue to conduct professional standards investigations, subject to civilian oversight by a complaints commissioner, who would have the authority to conduct an investigation when the commissioner thought it appropriate.

- In 1998, the *Police Act* continued the practice of police departments conducting professional standards investigations, subject to civilian oversight by an independent police complaint commissioner. The commissioner's oversight would be principally an after-the-fact review, without any power to conduct investigations himself or herself, but with the authority to order that another police department conduct the investigation.

- In 2002, the Special Committee of the Legislative Assembly recommended that the current model of the home police department conducting professional standards investigations continue, but that the PCC's mandate be broadened to "inquire into" the conduct of a municipal police officer.

- In 2006, the PCC recommended that professional standards investigations of death and serious injury cases should be removed from the home police department, and assigned to a specialized unit of police officers drawn from municipal police departments and the RCMP. If government deemed this alternative impractical, then such investigations should be assigned to the PCC.

- In 2007, former Justice Wood recommended that most professional standards investigations should remain with the home police department, subject to much more real-time oversight and direction by the PCC. However, professional standards investigations of in-custody and police-related deaths should always be conducted externally. Mr. Wood would not limit the scope of external agencies to another municipal police department or the RCMP.

H. The Experience in Other Canadian Jurisdictions

Several other Canadian jurisdictions have established schemes in which professional standards investigations are either conducted in the first instance by a civilian body, or a civilian oversight body has the authority to decide whether the home police department, another policing body or the civilian body itself will conduct the investigation.

1. Saskatchewan

In 2006, a new five-member civilian Public Complaints Commission was established to receive, investigate and review professional standards complaints against municipal police.[437] When the commission receives a complaint, it will determine whether investigations should be conducted by:

- the Public Complaints Commission itself, through its investigative staff,
- the police service whose member is the subject of the complaint,
- the police service whose member is the subject of the complaint, with the assistance of an observer appointed by the commission to monitor the investigation and report to the commission, or
- another police service.

If serious injury or death has occurred while a person was in custody or as a result of police action, the municipal police service must request that the Deputy Minister of Justice appoint an investigation observer from another police service or the RCMP. This investigation observer will monitor the investigation and report back to the Deputy Minister.

2. Manitoba

The Law Enforcement Review Agency is an independent non-police agency established under the *Law Enforcement Review Act* in 1985, to investigate professional standards complaints about the municipal police.[438] The agency itself investigates all complaints through interviews, taking statements, reviewing reports and making other relevant inquiries.

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[437] See http://www.justice.gov.sk.ca/publiccomplaintscommission, and http://www.justice.gov.sk.ca/PCC2006-2007AR.
[438] See http://www.gov.mb.ca/justice/lera/index.html.

Except where the commissioner decides that no further action will be taken on a complaint, the Act provides for three ways to resolve a complaint:

- informal resolution through mediation, which requires that both the complainant and the officer agree on this process,
- admission of disciplinary default, in which case the commissioner reviews the officer's service record and consults with the police chief before imposing a penalty, or
- referral to a Provincial Court judge for a hearing, if there is no admission of disciplinary default. The judge may impose any penalty set out in the Act.

3. Ontario

In June 2004, the Ontario government asked former Justice Patrick J. LeSage, Q.C., to review the provincial system for dealing with complaints against police officers. After wide-ranging consultations, and examination of the complaints systems in numerous other jurisdictions, he concluded[439] that:

> I am not convinced that a system totally removed from the police is in the best interests of the community or the police in Ontario. However, I am of the view that significant systemic changes, which include civilian oversight and monitoring of the complaints process, need to be made to improve confidence in how complaints regarding the police are handled (p. 58).

More specifically, he recommended that:

- An independent civilian body should be created to administer the public complaints system. This new body would educate the public about the complaints system, be responsible for the intake of complaints, provide assistance to complainants, and review complaints to decide whether they should be pursued.
- This new body would categorize complaints as policy, service, conduct or any combination.
- Policy and service complaints should continue to be handled in the current manner.

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[439] *Report on the Police Complaints System in Ontario*, April 22, 2005. See http://www.attorneygeneral.jus.gov.on.ca/english/about/pubs/LeSage/en-fullreport.pdf.

- Upon review of a complaint, the new body should determine whether it might be suitably resolved through informal mediative-type resolution.

- Where the new body considers informal resolution to be inappropriate, or it has been rejected or failed, the new body may refer the complaint for investigation.

- The new body will decide who will conduct the investigation—the home police service, another police service or the new body itself.

- In making that determination, the new body will take into account the nature of the complaint, the circumstances surrounding the complaint, the public interest, the size of the police service, the rank of officer and any other relevant factors.

- The new body must be given powers and resources to enable it to properly investigate a complaint, as well as the authority to oversee a complaint investigated by the police and to reassign an investigation at any stage.

- The new body should be staffed by highly skilled investigators. None may be active police officers, but up to half may be former police officers.

In 2007, the Legislative Assembly of Ontario enacted amendments to the *Police Services Act*,[440] implementing many of Mr. LeSage's recommendations. A new Independent Police Review Director will assume responsibility for the entire complaint process, and will decide whether the director's office, the home police service, or another police service will investigate a complaint.

I. Developing a New Approach to the Investigation of Police-Related Deaths

1. Conclusions drawn from this analysis

Based on my review of this issue, as discussed above, I have reached several conclusions.

First, I have not conducted the wide-ranging inquiry into professional standards investigations that Mr. Wood did, and it would consequently be inappropriate for me to comment on the overall architecture of Part 9 of the *Police Act*. I will limit my analysis to professional standards investigations arising out of police-related deaths, such as occurred after Frank Paul's death.

[440] *Independent Police Review Act*, 2007, Bill 103.

Second, it is timely that I should contribute to the public discussion on this issue, given this inquiry's examination of how the professional standards investigation was carried out in the Frank Paul case (including pleas from several participants for reforms), and given the provincial government's stated intention to introduce amendments to Part 9 of the *Police Act*. In the February 12, 2008, Speech from the Throne,[441] the government's intention was articulated as follows:

> Amendments to the *Police Act* will aim to implement Josiah Wood's recommendations to improve transparency, accountability and public confidence in the police complaints process.

Third, if my recommendations respecting criminal investigations of police-related deaths (see Part 6 of this report) are implemented, then that may well have an impact on how professional standards investigations of such cases should be conducted. Let me explain what I mean.

As I discussed in Part 6, conflict of interest and divided loyalties are the Achilles heel of the police (and especially the home police department) conducting criminal investigations of police-related deaths. In my view, the same problem permeates professional standards investigations.

Earlier in this part, I summarized several British Columbia reports that have recommended reforms to the police complaints system. My reading of those reports satisfies me that everyone acknowledges that conflict of interest pervades the current regime, and that the development of our civilian oversight system has been a reaction to that reality. Although it has not been articulated in quite this way, British Columbia's approach to police complaints has been to say: "We recognize that there is a conflict of interest in the police conducting professional standards investigations of themselves but, rather than eliminate the conflict, we will put in place a civilian oversight system to act as a watchdog."

Having confronted the conflict of interest issue in Part 6 of this report, I feel compelled to do so again in this part, at least to the extent that it applies to professional standards investigations of police-related deaths.

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[441] See http://www.leg.bc.ca/hansard/38th4th/H80212p.htm, p. 9627.

How, then, should professional standards investigations of police-related deaths be conducted? To answer that question, we need to go back to the criminal investigation of those same deaths. If they are conducted in a competent manner that eliminates any risk of conflict of interest, then they should result in thorough and impartial reports, and in equally competent, thorough and impartial decisions about whether criminal charges will be laid. If that happens, then the focus of subsequent professional standards investigations should be significantly narrower than at present. Before turning to that issue, I will comment on "the duty to cooperate."

2. The duty to cooperate

A central issue in the ongoing debate about the investigation of police complaints relates to a police officer's duty to cooperate. Mr. Wood summarized the history surrounding this issue at paragraphs 154–172 of his report.

As discussed in Part 6 of this report, my review of the practice within the VPD leads me to conclude that an accommodation has been reached between the union and management respecting the extent to which a respondent police officer must cooperate in a criminal investigation and in a subsequent professional standards investigation arising out of a police-related death.

A single policy appears to apply to both types of investigations—the respondent officer *may* (but is not required to) agree to be interviewed by the investigating officer, but *must* complete a written duty report which sets out the officer's involvement in the incident. The respondent officer normally has up to five business days to complete the duty report, which is often completed with the assistance of a union representative and legal counsel.

This policy and practice is, in my view, problematic. On the one hand, it imposes a duty on the respondent officer to give a written statement to the investigating officer in the criminal investigation, when no such duty is imposed generally on a person who is the subject of a criminal investigation. On the other hand, it does not require the respondent officer to cooperate fully in the professional standards investigation (for example, by being interviewed or by being required to produce

all relevant documents under the officer's control), contrary to the standard that exists in most self-governing professions. [442]

In the context of professional standards investigations, I agree with the PCC's view, set out at page 24 of his White Paper:

> It is in my view inappropriate for respondent officers to be protected from the usual obligation to provide evidence in a regulatory discipline process. As made clear in the preamble to this White Paper, the police complaint process is not properly understood to be a quasi-criminal proceeding. It is an error to assume that respondents have, or that the process requires the respondent to have, the right to remain silent. The discipline process is a civil regulatory proceeding. As with other civil proceedings and modern regulatory statutes dealing with professional conduct, the obligation to respond promptly, fully and truthfully to allegations of misconduct is a legal and ethical duty properly attached to the privilege of being a professional.

To the PCC, the duty to cooperate has several dimensions. It encompasses a duty to cooperate during the professional standards investigation itself and, as well, during the commissioner's oversight of that investigation. It includes an obligation to make and preserve records about an incident in accordance with directives issued by the PCC, a duty to promptly produce documents when requested by the PCC, and a duty to attend before the PCC's counsel for an interview prior to a public hearing (unless the officer is the respondent officer). Failure to comply with these requirements would constitute the disciplinary default of neglect of duty.[443]

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[442] For example, in *McPherson v. Institute of Chartered Accountants of British Columbia* (1988), 55 B.C.L.R. (2d) 286 (B.C.C.A.) the Court upheld the institute's practice review and licencing rules, including the rule empowering the practice review officer to examine and take copies of documents including client files. The rules violated neither sections 7 nor 8 of the Charter. See also *Greene v. Law Society of British Columbia* (2005), 40 B.C.L.R. (4th) 125 (B.C.S.C) and *College of Physicians and Surgeons of British Columbia v. Bishop* (1989), 56 D.L.R. (4th) 164 (B.C.S.C.). In *James v. Law Society of British Columbia* (1982), 143 D.L.R. (3d) 379 (B.C.S.C.), the court ruled that disciplinary proceedings were civil in nature and consequently the member was a compellable witness. This constituted neither a breach of natural justice, nor a contravention of s. 11 of the Charter (which applied only to criminal matters). See also *British Columbia (Securities Commission) v. Branch* (1992), 123 D.L.R. (4th) 462 (S.C.C.).

[443] See White Paper, p. 14, and section 14 of the PCC's draft *Police Complaint Act*.

In his 2007 report, Mr. Wood endorsed the commissioner's analysis, and made several recommendations including proposed amendments to the *Police Act* respecting the duty to cooperate:

> 29. Part 9 be amended to provide that every municipal constable, chief constable and deputy chief constable has a duty to cooperate fully with any investigation conducted under Part 9 of the Act.
>
> 30. Part 9 be further amended to provide that every municipal constable, chief constable and deputy chief constable has a duty to cooperate with the police complaint commissioner, and his properly delegated staff, in the exercise of the powers and duties of that office under Part 9 of the Act.
>
> 31. Division 4 of Part 9 be amended by adding a section containing an express duty on the part of respondent or witness officers to provide a statement, and to submit to an interview, within 5 days of being called upon to do so by an officer conducting an investigation into a public trust complaint, such deadline to be subject only to a discretion on the part of the discipline authority, in special circumstances, to grant an extension.
>
> 32. Division 4 of Part 9 be further amended to provide that any statement so provided shall be admissible in any proceedings under the *Police Act*, but cannot, under any circumstances, excepting a prosecution for perjury, be admitted into evidence in any civil or criminal proceeding.
>
> 33. Section 5 of the *Code of Professional Conduct Regulation* be amended to provide an additional category of discreditable conduct in the form of a failure to cooperate with any investigation or a failure to provide a statement or to submit to an interview when called upon to do so by an investigating officer.
>
> 34. Part 9 of the Act be amended by adding thereto a section which provides that a justice of the peace, who is satisfied by information on oath that there are reasonable grounds to believe that there is in a building, receptacle or place anything that there are reasonable grounds to believe will afford evidence with respect to the commission of a disciplinary default under the *Code of Professional Conduct Regulation* may, at any time, issue a warrant authorizing a discipline authority or a municipal constable, chief constable or deputy chief constable conducting any investigation under Part 9 to search the building, receptacle or place for any such thing and to seize it. Such a provision should be accompanied by the usual safeguards relating to the custody,

> preservation and ultimate disposal of such evidence following conclusion of the investigation in question.

I agree with these recommendations.

Recommendation 34, above, recommends an administrative search warrant provision, as the PCC had proposed in his White Paper. While I do not question the appropriateness of such a provision, consideration might also be given to imposing a duty on a police officer to produce to an investigator, when demanded, all notes, reports or other documents, or information in any other form, either created by or in the possession or control of the officer that are relevant to the incident.

3. The nature of the professional standards investigation

If every police-related death becomes the subject of a criminal investigation, *and* if every such investigation is conducted independently by an entity such as the IIO proposed in Part 6 of this report, *and* if witness officers are required to cooperate fully in the investigation, then the criminal investigation report should set out all the relevant facts, including statements from civilian and police officer witnesses. In that case, the subsequent professional standards investigation would, in most cases, focus on three matters:

- obtaining information from the respondent officer about the incident,
- making a determination whether a disciplinary default has occurred, and
- if a disciplinary default has occurred, deciding on an appropriate disciplinary measure.

4. Alternative organizational approaches

Having thus identified the principal responsibilities of the investigator in a professional standards investigation of a police-related death, I turn now to a consideration of the various organizational alternatives for the conduct of such investigations. Professional standards investigations could be conducted:

- by the home police department, subject to much more real-time oversight and direction by the PCC,
- by another police department, the RCMP or some other external agency,

- by a specialized unit of police officers drawn from municipal police departments and the RCMP, or
- by the PCC.

a. Police-based professional standards investigations

All three police-based alternatives noted above (the home department, another police department, or a specialized unit of police officers drawn from municipal police departments) give rise to a common concern—they are instances of the police investigating themselves.

Given this concern, the risk of divided loyalties tainting a professional standards investigation is reduced if the underlying *criminal* investigation is done by a civilian entity (such as my proposed Independent Investigation Office) and if there is a duty on the respondent officer to cooperate fully in the professional standards investigation. If the officer conducting the professional standards investigation is required to prepare a thorough report summarizing all investigative measures taken and giving detailed reasons for the investigator's decisions, then the process is transparent and thus susceptible to effective oversight by the PCC.

I am not persuaded, however, that even in these circumstances, there would be general public acceptance of the police investigating themselves. As noted in Part 6, that concern would be highest if the home police department conducted the investigation, and would become less so, if the investigation was assigned to another police department or to a specialized unit of police officers.

In my view, it is absolutely necessary for the public to have confidence in professional standards investigations of police-related deaths. I note that a public awareness survey conducted as part of Mr. Wood's study found that only 55 percent of those responding were confident (42 percent) or very confident (13 percent) with the existing process for handling complaints against the police.[444] I am reluctant to recommend

[444] See Wood Report, Appendix E: *Report on the Public Awareness Survey Conducted for the Review of the Police Complaint Process in British Columbia*, p. 8. Of the remaining 45 percent of respondents, 5 percent were not confident at all, 13 percent were not very confident, and 27 percent were neutral. According to the study, the sample of 1,024 yielded a margin of error of ±3 percentage points 19 times out of 20.

any regime that would perpetuate the current practice of the police investigating themselves in the most sensitive of such cases—police-related deaths.[445]

b. Civilian-based professional standards investigations

The alternative to a police-based professional standards investigation of police-related deaths is for the PCC to conduct such investigations. On balance, I favour this approach. It eliminates all concerns about conflict of interest, and it should not place an inordinate load on the commissioner, if my estimate of the number of police-related deaths per year (see Part 6) is accurate.[446]

In advocating this approach, I recognize that it necessitates a qualitative change to the role of the PCC—the overseer now becomes the investigator. The commissioner would assume, in such cases, many of the powers and responsibilities of the "discipline authority" (currently the chief constable or his or her designate), including the responsibility to determine whether a disciplinary default has occurred and, if so, an appropriate disciplinary measure (perhaps after consultation with the chief constable, as in Manitoba).

It also raises the question of the extent to which those affected by the PCC's decisions in cases of police-related deaths (i.e., the respondent officer, the home police department and any third-party complainant) should have an avenue to review those decisions.

I do not think it would be appropriate for me to engage in a detailed examination of this issue, given Mr. Wood's exhaustive study of all aspects of the Part 9 scheme and his detailed recommendations for reform, including creation of a new streamlined "public review" process as

[445] However, if it is ultimately decided that a police-based entity should conduct professional standards investigations of police-related deaths, then I endorse Mr. Wood's suggestion that the PCC's oversight needs to occur during, not after, such investigations, and that it must be based on full access to the investigation as it occurs. For such oversight to occur, all complaint files would need to be stored electronically, and the PCC's staff would need to have ongoing electronic access to them.

[446] While I do not wish to downplay the amount of time and resources that the PCC will need to devote to such professional standards investigations, they will be offset by the PCC no longer having to oversee a police department's professional standards investigation of such cases including, in some instances, a public hearing.

an alternative to a full public hearing. I will say that I am satisfied that the PCC and his staff would bring competence and impartiality to bear when conducting professional standards investigations arising from police-related deaths. That confidence extends to the PCC's decisions about whether a disciplinary default has occurred and, if so, an appropriate disciplinary measure. If the PCC and his staff have been given the legislative mandate to oversee such investigations, surely they have the necessary competence to conduct them in the first instance.

However, given my recommendation that this small subset of professional standards investigations should be conducted by the PCC (and not by an external police department as proposed by Mr. Wood), it may be necessary to refine Mr. Wood's recommendations insofar as they apply to police-related deaths. For example, there may be circumstances in which a third-party complainant should have an opportunity to review the PCC's decision about the disciplinary measures imposed on an officer arising out of a police-related death.

J. Recommendations

11. I recommend that the statutory mandate of the Police Complaint Commissioner be extended to include the requirement that the commissioner conduct professional standards investigations of all police-related deaths arising in those British Columbia jurisdictions policed by municipal police departments.

12. I recommend that Recommendations 29–34 of Mr. Wood's 2007 Report be implemented.

ABBREVIATIONS AND ACRONYMS

ALST	The Aboriginal Legal Services of Toronto
BCCLA	BC Civil Liberties Association
B.C.S.C.	British Columbia Supreme Court
CAD	Computer Assisted Drawing
CPIC	Canadian Police Information Centre
Cst.	Constable
Det.	Detective
FNLC	First Nations Leadership Council
IIO	Independent Investigation Office
IIS	Internal Investigation Section
Insp.	Inspector
Jail	Vancouver Jail, 312 Main Street
Manual	VPD's *Regulations and Procedures Manual*
NCO	Non Commissioned Officer
NFA	No Fixed Address
OPCC	Office of the Police Complaint Commissioner
PCC	Police Complaint Commissioner
RCMP	Royal Canadian Mounted Police
R.S.B.C.	Revised Statutes of British Columbia
Sgt.	Sergeant
SIU	Special Investigation Unit, Ontario
H/SIPP	Hold/State of Intoxication in a Public Place
UNNS	United Native Nations Society
VPD	Vancouver Police Department

APPENDICES

Appendix A

Purpose and Terms of Reference

Purpose:

(a) to provide Mr. Paul's family and the public with a complete record of the circumstances relating to Mr. Paul's death;

(b) to recommend changes considered necessary to the rules, policies and procedures referred to in section 4(c), (d) and (e).

Terms of reference:

(a) to conduct hearings, in or near the City of Vancouver, into the circumstances surrounding the death of Mr. Paul;

(b) to make findings of fact regarding circumstances relating to Mr. Paul's death, including findings of fact respecting the response of British Columbia Ambulance Service, the Vancouver Police Department, the BC Coroners Service, the Office of the Police Complaints Commissioner and the Criminal Justice Branch of the Ministry of Attorney General to the death of Mr. Paul;

(c) to examine the rules, policies and procedures of the Vancouver police board and of the Vancouver police department respecting police interaction with persons who are incapacitated by alcohol or drug use, including directions for the handling, detention, transportation and release of individuals who, as a result of alcohol or drug use, are incapacitated, violent, unable to care for themselves, self-destructive or unconscious;

(d) to examine the rules, policies and procedures of the British Columbia Ambulance Service respecting the interaction of staff of the British Columbia Ambulance Service with persons who are incapacitated by alcohol or drug use, including directions for the handling and transportation of individuals who, as a result of alcohol or drug use, are incapacitated, violent, unable to care for themselves, self-destructive or unconscious;

(e) to examine the rules, policies and procedures of the BC Coroners Service, the Office of the Police Complaints Commissioner and the Criminal Justice Branch of the Ministry of Attorney General related to the role and response of each of those

offices where an individual dies in circumstances similar to the circumstances of Mr. Paul's death;

(f) to recommend changes considered necessary to the rules, policies and procedures referred to in paragraphs (c), (d) and (e);

(g) to identify the health care and social service programs and facilities available in the City of Vancouver that the police may access if a municipal constable determines that a person should not be detained but the person requires immediate health care or social services because the person is incapacitated by alcohol or drug use;

(h) to submit a final report to the Attorney General on or before May 31, 2008.[447]

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[447] Amended by Order in Council 310/2008 to November 30, 2008, and by Order in Council 881 to June 30, 2009.

Appendix B

Practice and Procedure Directive for Evidentiary Hearings

AUTHORIZED BY PUBLIC INQUIRY ACT, S. 9

NOVEMBER 26, 2007

Definitions

1. In this Directive,
   "Act" means the *Public Inquiry Act*, S.B.C. 2007, c. 9,
   "record" includes books, documents, maps, drawings, photographs, letters, vouchers, papers and any other thing on which information is recorded or stored by any means whether graphic, electronic, mechanical or otherwise.

Purpose Of The Evidentiary Hearings

2. The Commissioner will inquire into those matters set out in paragraphs (a) and (b) of the Terms of Reference. On the basis of oral and documentary evidence tendered during the evidentiary hearings, the Commissioner will make findings of fact and may make a finding of misconduct against a person or make a report that alleges misconduct by a person. The Commissioner's findings of fact or findings of misconduct cannot be taken as findings of criminal or civil liability.

Public And Media Access To Evidentiary Hearings

3. Subject to Rule 4, the Commission must:
   a. ensure that evidentiary hearings are open to the public, either in person or through broadcast proceedings, and
   b. give the public access to information submitted in an evidentiary hearing (see *Public Inquiry Act*, s. 25).
4. The Commissioner may, by order, prohibit or restrict a person or class of persons, or the public, from attending all or part of an evidentiary hearing, or

from accessing all or part of any information provided to or held by the Commission,

a. if the government asserts privilege or immunity over the information under section 29 of the Act,
b. for any reason for which information could or must be withheld by a public body under sections 15 to 19 and 21 to 22.1 of the *Freedom of Information and Protection of Privacy Act*,
c. if the Commission has reason to believe that the order is necessary for the effective and efficient fulfillment of the Commission's terms of reference (see *Public Inquiry Act*, s. 15(1)), or
d. if the Commissioner is satisfied that such an order would make available to the Commission evidence that would otherwise not be available due to a privilege under the law of evidence.

5. In making an order under Rule 4, the Commissioner shall not unduly prejudice the rights and interests of a participant against whom a finding of misconduct, or a report alleging misconduct, may be made (see *Public Inquiry Act*, s. 15(2)).

Video And Audio Recording Of The Evidentiary Hearing Proceedings

6. The Commissioner may impose restrictions on the video and audio recording of the evidentiary hearing proceedings and may, on application, order that there be no video or audio recording of some or all of a witness's testimony. The Commission will provide a separate room that may be used for electronic and print media interviews.

Reporting The Proceedings

7. The public and media may report the evidentiary hearing proceedings that are open to the public, except for testimony and/or submissions in respect of which the Commissioner has ordered that they shall not be published.

Application To Participate In The Evidentiary Hearings

8. A person may apply to be a participant by applying to the Commission in the manner and form it requires. The application must set out the basis upon which participation is sought, and the extent and nature of the participation sought.

9. The Commissioner may accept an applicant as a participant after considering all of the following:

a. whether, and to what extent, the person's interests may be affected by the findings of the Commission,
b. whether the person's participation would further the conduct of the inquiry,
c. whether the person's participation would contribute to the fairness of the inquiry (see *Public Inquiry Act*, s. 11(4)).

Powers Respecting Participants

10. Subject to Rule 13, the Commissioner may make orders respecting
    a. the manner and extent of a participant's participation,
    b. the rights and responsibilities of a participant, if any, and
    c. any limits or conditions on a participant's participation (see *Public Inquiry Act*, s. 12(1)).
11. In making an order under Rule 10, the Commissioner may
    a. make different orders for different participants or classes of participants, and
    b. waive or modify one or more of his orders as necessary (see *Public Inquiry Act*, s. 12(2)).
12. In making an order under Rule 10, the Commissioner must ensure that a participant who responds to a notice under section 11(2) of the Act has a reasonable opportunity to be heard by the Commissioner before the Commissioner makes a finding of misconduct against the participant, or makes a report that alleges misconduct by that participant (see *Public Inquiry Act*, s. 12(3)).

Rights Of Participants

13. A participant may
    a. participate on his or her own behalf, or
    b. be represented by counsel or, with the approval of the Commissioner, by an agent (see *Public Inquiry Act*, s. 13(1)).
14. A participant
    a. has the same immunities as a witness who appears before the court, and
    b. is considered to have objected to answering any question that may
        i. incriminate the participant in a criminal proceeding, or
        ii. establish the participant's liability in a civil proceeding (see *Public Inquiry Act*, s. 13(2)).

Confidentiality Of Records

15. Commission Counsel shall not provide a record to counsel, a participant or a witness until that person has delivered to Commission Counsel a signed undertaking, in a form approved by the Commission, that all records disclosed by the Commission will be used solely for the purposes of the Inquiry.

16. Counsel for a participant or a witness shall not provide a record to the participant or witness until the participant or witness has delivered to counsel a signed undertaking, in a form approved by the Commission, and counsel has delivered that signed undertaking to Commission Counsel.

17. The Commissioner may:
    a. impose restrictions on the use and dissemination of records,
    b. require that a record that has not been entered as an exhibit in the evidentiary proceedings, and all copies of the record, be returned to the Commission, and
    c. on application, release counsel, a participant or a witness, in whole or in part, from the undertaking in relation to any record, or may authorize the disclosure of a record to another person.

Records

18. A participant must, at the earliest opportunity and in any event at least 14 days before using a record in an evidentiary hearing or tendering it as an exhibit, deliver a copy of the record to Commission Counsel.

Public Access To Records

19. Unless the Commissioner orders otherwise:
    a. a record within the Commission's control that has not been entered as an exhibit is not available for public inspection or copying, and
    b. a record that has been entered as an exhibit may be inspected by the public and the media. The Commission will determine the circumstances in which a charge will be imposed for copying records.

Applications to the Commissioner

19.1. A participant may apply to the Commissioner for an order by:
    a. preparing the application in writing,
    b. attaching to the application any supporting materials, and

c. delivering the application and supporting materials to the Commission by email, to commissioncounsel@frankpaulinquiry.ca in Microsoft Word or *.PDF format.

19.2. An applicant must deliver the application to the Commission at least two days before the application is to be heard.

19.3. A participant who wishes to receive notice of an application shall provide the Commission with an email address for delivery.

19.4. The Commission shall promptly deliver the application and supporting materials, by email, to each other participant who has provided the Commission with an email address for delivery.

Applications for Further Disclosure of a Record

19.5. A participant may seek disclosure of a record from another person ("record holder") by asking Commission Counsel, in writing, to use the powers of the Commission to obtain the record.

19.6. The request must state:

a. the reasons the participant believes the record holder possesses the record, and

b. the reasons the participant believes the record is relevant to a matter before the Commission.

19.7. If Commission Counsel accepts the request, he will attempt to obtain the record.

19.8. If Commission Counsel rejects the request, he shall notify the participant, and the participant may apply to the Commissioner, in accordance with Rules 19.1 to 19.4, for an order respecting the request.

19.9. When the participant applies to the Commissioner under Rule 19.8, the Commission shall deliver the application and any supporting materials to the record holder, and to each other participant who has provided the Commission with an email address for delivery.

19.10. Unless the Commissioner orders otherwise, the procedures set out in Rules 19.5 to 19.9, in relation to a particular witness, should whenever possible be completed before that witness commences his or her testimony.

Witnesses

20. Each participant shall provide to Commission Counsel at the earliest opportunity the name and address of any person who the participant believes should be called as a witness during the evidentiary hearings, with a statement of the

subject matter of their proposed testimony, their experience and background, and the estimated length of their testimony.

21. The following rules apply to witnesses:
    a. Commission Counsel shall decide who shall be called as a witness at the evidentiary hearings,
    b. subject to Rule 22, Commission Counsel shall call and examine witnesses on behalf of the Commission, and may adduce evidence by way of both leading and non-leading questions,
    c. each witness called shall, before testifying, be sworn or affirm,
    d. each witness who testifies may during his or her testimony be represented by counsel or, with the approval of the Commissioner, by an agent,
    e. the Commissioner may, on application by a participant, permit a participant to cross-examine a witness to the extent of that participant's interest. If the participants are unable to agree on an order of cross-examination, the Commissioner will determine the order,
    f. subject to Rule 22, counsel for a participant is entitled to examine that participant last, regardless of whether or not counsel is also representing another participant,
    g. after Commission Counsel has called all witnesses on behalf of the Commission, a participant may apply to the Commissioner for permission to call a witness and, if permission is granted, subrules (c) to (e) apply to each witness called by a participant.
    h. Commission Counsel has the right to re-examine any witness who has testified.
22. Counsel for a witness may apply to the Commissioner for permission to lead that witness's examination in chief. If permission is granted, counsel will examine the witness in accordance with the normal rules governing the examination of one's own witness in court proceedings, unless the Commissioner directs otherwise.

Power To Accept Information

23. The Commissioner may receive and accept information that he considers relevant, necessary and appropriate, whether or not the information would be admissible in any court (see *Public Inquiry Act*, s. 14(1)).
24. Without limiting Rule 10, the Commissioner may exclude anything unduly repetitious (see *Public Inquiry Act*, s. 14(2)).
25. Nothing in Rule 23 overrides the provisions of any Act expressly limiting the extent to which or purposes for which any oral testimony, records or things may be admitted or used in evidence (see *Public Inquiry Act*, s. 14(3)).

26. A person cannot be compelled to disclose in an evidentiary hearing anything that, in any court, would be privileged under the law of evidence (see *Public Inquiry Act*, s. 22(2)).

Final Submissions

27. Commission Counsel, and each participant authorized to do so, may make final oral and written submissions to the Commissioner on any issue within the Commission of Inquiry's Terms of Reference.

28. The Commissioner may set time limits on oral submissions, and page limits on written submissions.

The Commission's Process

29. Subject to the Act and the Commission's Terms of Reference, the Commission has the power to control its own process (see *Public Inquiry Act*, s. 9(1)).

Participant's Failure To Comply With This Directive

30. Without limiting any other powers of enforcement, if a participant fails to comply with this directive, including any time limits specified for taking any actions, the Commissioner, after giving notice to the participant, may do any of the following:
    a. schedule a meeting or hearing,
    b. continue with the inquiry and make a finding or recommendation based on the evidence before him, with or without providing an opportunity for submissions from that participant,
    c. make any order necessary for the purpose of enforcing this directive (see *Public Inquiry Act*, s. 17).

Commissioner's Discretion

31. The Commissioner retains a residual discretion to amend, add to, vary or depart from any of these procedural Rules for the effective conduct of the evidentiary hearings.

Appendix C

Participants

Section 11 of the *Public Inquiry Act* provides for two categories of participants:

1. a person who is provided with a notice under s. 11(2) that the commission intends to make a finding of misconduct against that person, or intends to make a report that alleges misconduct by that person. No one has been given participant status under this provision.
2. a person who is accepted as a participant under subsection (4), which provides that a commission may accept the applicant as a participant after considering all of the following:
    - whether, and to what extent, the person's interests may be affected by the findings of the commission,
    - whether the person's participation would further the conduct of the inquiry,
    - whether the person's participation would contribute to the fairness of the inquiry.

The following organizations and individuals have been accepted as participants under s. 11(4) of the Act (see Commissioner's Rulings, Appendices F through J):

Participant	Counsel
Aboriginal Legal Services of Toronto	Kimberly Murray and Jonathan Rudin
BC Ambulance Service/EHS Commission	Douglas Eastwood
BC Civil Liberties Association	Michael Tammen, Grace Pastine and Catherine Wong
Constable David Instant	David Crossin, Q.C., and Michael Shirreff
BC Coroners Service	Rodrick MacKenzie and Steven Boorne
Criminal Justice Branch at the Ministry of Attorney General	Richard Peck, Q.C., and Timothy Hinkson
First Nations Leadership Council	Steven Kelliher
Paul Family	Steven Kelliher
Police Complaint Commissioner:	
Current PCC Dirk Ryneveld	Frank Falzon, Q.C.
Former PCC Don Morrison	Joseph Arvay, Q.C., and Elin Sigurdson
Former PCC Benjamin Casson	Terrence Robertson, Q.C., and Kathleen Kinch
Russell Sanderson	Kevin Woodall
United Native Nations Society	Cameron Ward, David Eby and Lobat Sadrerhashemi
Vancouver Police Department and Vancouver Police Board	George Macintosh, Q.C., Sean Hern and Anthony Price

Appendix D

Evidentiary Hearings, Witnesses and Speakers

Matthew Jarvie ADIE

April 4, 2008

Joseph ALBERT, Abbott Mansions

November 16, 2007

Mike BERRY, BC Ambulance Service

November 22, 2007

Terry Edmund BLYTHE, VPD

February 27, 2008

Donald Ivan BOUTIN, VPD

February 11, 2008
February 12, 2008

Neil BOYD, Professor

April 28, 2008

Isabel Ruth BRANDON, Nurse

February 14, 2008

Lawrence BUTLER, VPD

November 21, 2007

Dr. John BUTT, Private Consultant in Forensic Medicine

March 19, 2008
May 6, 2008

Len CALLARD, VPD

January 30, 2008

Larry CAMPBELL, BC Coroners Service

January 25, 2008

Benjamin CASSON, Office of the Police Complaint Commissioner

March 19, 2008

Dr. Jim CHRISTENSON, Vice-President of Medical Programs for the Emergency Health Services Commission

May 5, 2008

Peggy CLEMENT, Frank Paul family member

November 13, 2007

John COLLENS, Vancouver Detox Centre

November 27, 2007

Barry CONROY, Saferide

November 16, 2007

Pam DAWES, VPD

November 19, 2007

John DE HAAS, VPD

February 21, 2008

Daniel Alexander DICKHOUT, VPD

February 13, 2008

James DOUGLAS, BC Ambulance Service

November 16, 2007

Anne DRENNAN, VPD

February 13, 2008

Douglas EASTWOOD

May 5, 2008

Darryl ELL, VPD

November 29, 2007

James ENGLISH, VPD

November 29, 2007

Frank FALZON, Q.C., Office of the Police Complaint Commissioner

May 8, 2008

Dr. James FERRIS

January 15, 2008

Ward FINDLAY, BC Ambulance Service

November 23, 2007

Greg FIRLOTTE, Corrections Officer

November 28, 2007

Kenneth John FRAIL, VPD

January 29, 2008
January 30, 2008

Sarah GOFORTH, Director of Recovery Engagement Services at Central City Concern

April 28, 2008

Dr. Laurel GRAY, Pathologist

January 16, 2008

Fernando GROSSLING, BC Ambulance Service

November 23, 2007

Eric Oscar GRUMMISCH, VPD

January 30, 2008

John Michael GRYWINSKI, VPD

February 19, 2008

Brett HALLGREN, VPD

February 26, 2008

Sean HERN, Counsel for the VPD

May 6, 2008

Andrew William HOBBS, VPD

February 13, 2008

Timothy HOUCHEN, VPD

November 19, 2007

David INSTANT, VPD

January 9, 2008
January 11, 2008

Lisa JAMES, VPD

January 30, 2008

Gareth JONES, Director, Special Ombudsman Response Team

May 7, 2008

Frances JOURDAIN, Paul Family

February 26, 2008

Daniel JOURDAIN, Paul Family

February 26, 2008

David KELLY

November 30, 2007

Cheryl LEGGETT, VPD

January 31, 2008

Norm LEIBEL, BC Coroners Service

January 29, 2008
May 5, 2008

Patrick LEWIS

November 23, 2007

Donna LISTER, BC Coroners Service

November 30, 2007
February 26, 2008

Dr. Shabehram LOHRASBE, Psychiatrist

April 4, 2008

Currie LOW, Nurse, Vancouver Detox Centre

November 26, 2007

Ken LOW, Corrections Officer

November 26, 2007

William MACDONALD, Office of the Police Complaint Commissioner

March 18, 2008
March 19, 2008
April 3, 2008

Rodrick MACKENZIE, Counsel, BC Coroners Service

May 5, 2008

Art MANUEL, Manager of the Annex Harm Reduction Program and Co-director of the Infirmary Program

April 28, 2008

André MARIN, Ombudsman of Ontario

May 7, 2008

Linnett MCKENNA, VPD Custodial Guard

November 29, 2007

Brian MORGAN, Saferide

November 21, 2007

Don MORRISON, Office of the Police Complaint Commissioner

March 12, 2008
March 13, 2008

Richard A. MULDER, VPD

November 20, 2007

Barbara MURPHY, Office of the Police Complaint Commissioner

March 17, 2008
March 18, 2008

Tony O'BUCK, Correctional Officer

November 30, 2007

Marilyn OBERG, BC Ambulance Service

November 22, 2007

Derek PETERSON, VPD

November 27, 2007

Michael PORTEOUS, VPD

February 21, 2008

Brian PORTER, VPD

January 14, 2008

Jean PRINCE, VPD

November 19, 2007

Michelle RENVILLE, Corrections Officer

November 20, 2007
November 21, 2007

Peter RITCHIE, Civil Litigation and Criminal Defence Lawyer

May 1, 2008

Jeannine ROBINSON, BC Coroners Service

January 23, 2008
January 24, 2008

Janet ROSS, Corrections Officer

November 19, 2007

Robert George ROTHWELL, VPD

January 31, 2008
February 1, 2008

Dirk RYNEVELD, Office of the Police Complaint Commissioner

March 13, 2008
March 14, 2008

Russell SANDERSON, VPD

January 7, 2008
January 8, 2008
January 9, 2008

Terry SMITH, BC Coroners Service

January 28, 2008
May 5, 2008

Robert Douglas STAUNTON, VPD

February 14, 2008

Dr. Tomislav SVOBODA

April 28, 2008

Robert TURNER, VPD

November 26, 2007
November 27, 2007

Dana URBAN, Office of the Police Complaint Commissioner

April 2, 2008
April 3, 2008

Cameron WARD, Counsel, United Native Nations Society

May 1, 2008
May 8, 2008

Ray WINTERS, VPD

November 29, 2007

George WOOD, VPD

January 14, 2008

Sherryl YEAGER, BC Coroners Service

January 24, 2008

Appendix E

Public Submissions

Name	Community
Gunargie Cheryl O'Sullivan	Vancouver, BC
John Harvey	(by email)
Stephen Samuel	Vancouver, BC
Charles Boylan	(by email)
Georgia Brown	(by email)
Bill Lightbown	Vancouver, BC
Barbara Moyle	Vancouver, BC
James Millier	Big Cove, NB

Appendix F

RULING #1
Applications for Participant Status
October 17, 2007

THE FRANK PAUL INQUIRY
WILLIAM H. DAVIES, Q.C., COMMISSIONER
APPOINTED UNDER THE PUBLIC INQUIRY ACT,
S.B.C. 2007, C. 9

Introduction

1. I have been appointed by the Government of British Columbia as Commissioner for a public inquiry in the case of Frank Joseph Paul. This Commission of Inquiry—and my responsibilities—are governed by the recently enacted *Public Inquiry Act*, S.B.C. 2007, c. 9.

2. One of these duties is to determine who may participate in this public inquiry, and to what extent.

3. This is my ruling on that issue.

Background

4. Mr. Paul, a member of the Mi'kmaq Nation from New Brunswick, was found dead in an alleyway in Vancouver on December 6, 1998. An autopsy concluded that he died from hypothermia due to exposure/alcohol intoxication. Mr. Paul had been in the custody of Vancouver Police in the hours before his death; he was removed from lockup, and left by a police officer in the alleyway.

5. This statement of the facts is necessarily brief and preliminary, because these matters have not been subject to any judicial fact-finding, and this Commission of Inquiry has yet to commence hearings.

6. On August 10, 2007, the BC Ministry of Attorney General announced the Purpose and Terms of Reference for this inquiry. As the Terms of Reference are of central importance to this ruling, I will reproduce them:

> WILLIAM H. DAVIES, QC, COMMISSION OF INQUIRY
> PURPOSE AND TERMS OF REFERENCE
>
> Purpose:
>
> (a) to provide Mr. Paul's family and the public with a complete record of the circumstances relating to Mr. Paul's death;
>
> (b) to recommend changes considered necessary to the rules, policies and procedures referred to in section 4(c), (d) and (e).
>
> Terms of reference:
>
> (a) to conduct hearings, in or near the City of Vancouver, into the circumstances surrounding the death of Mr. Paul;
>
> (b) to make findings of fact regarding circumstances relating to Mr. Paul's death, including findings of fact respecting the response of British Columbia Ambulance Service, the Vancouver Police Department, the BC Coroners Service, the Office of the Police Complaints Commissioner and the Criminal Justice Branch of the Ministry of Attorney General to the death of Mr. Paul;
>
> (c) to examine the rules, policies and procedures of the Vancouver police board and of the Vancouver police department respecting police interaction with persons who are incapacitated by alcohol or drug use, including directions for the handling, detention, transportation and release of individuals who, as a result of alcohol or drug use, are incapacitated, violent, unable to care for themselves, self-destructive or unconscious;
>
> (d) to examine the rules, policies and procedures of the British Columbia Ambulance Service respecting the interaction of staff of the British Columbia Ambulance Service with persons who are incapacitated by alcohol or drug use, including directions for the handling and transportation of individuals who, as a result of alcohol or drug use, are incapacitated, violent, unable to care for themselves, self-destructive or unconscious;
>
> (e) to examine the rules, policies and procedures of the BC Coroners Service, the Office of the Police Complaints Commissioner and the Criminal Justice Branch of the Ministry of Attorney General related to the role and response of each of those offices where an individual dies in circumstances similar to the circumstances of Mr. Paul's death;
>
> (f) to recommend changes considered necessary to the rules, policies and procedures referred to in paragraphs (c), (d) and (e);

(g) to identify the health care and social service programs and facilities available in the City of Vancouver that the police may access if a municipal constable determines that a person should not be detained but the person requires immediate health care or social services because the person is incapacitated by alcohol or drug use;

(h) to submit a final report to the Attorney General on or before May 31, 2008.

7. It is intended that this Commission of Inquiry will have four "phases" of public hearings. The first phase will entail the factual determination of what occurred on December 5–6, 1998, the night Mr. Paul died. The second phase will look at the response of various agencies to Mr. Paul's death. The third phase will focus on identifying health care and social service programs and facilities. The fourth and final phase will be policy-based, and will consider recommending changes to rules, policies and procedures.

Legislation

8. The governing legislation is the 2007 *Public Inquiry Act*, *supra*. In s. 11, the Act sets out who may participate in a Commission of Inquiry such as this. There are two categories of "participants" under s. 11. The first is those persons who are given notice that they may be subject to a finding of misconduct or a report alleging misconduct. As no such notices have been issued to date in this inquiry, this first category is not in play.

9. The second category of participants comprises those who apply to the Commission to be accepted as participants. It is this category that we are concerned with here. The key provision is s. 11(4), which reads:

> 11(4) On receiving an application under subsection (3), a commission may accept the applicant as a participant after considering all of the following:
>
> (a) whether, and to what extent, the person's interests may be affected by the findings of the commission;
>
> (b) whether the person's participation would further the conduct of the inquiry;
>
> (c) whether the person's participation would contribute to the fairness of the inquiry.

10. These are the criteria that have guided my analysis and determination of who should be accepted as participants for this Commission of Inquiry.

11. The legislation does not specify what rights may be granted to participants, but it is uncontroversial to say that participation would typically include access to documents (according to the commission's procedural rules); a seat at counsel table; and the opportunity to make closing submissions. Depending on the extent of participation authorized, a participant might or might not be permitted to apply to call witnesses or suggest what witnesses should be called; and might or might not be permitted to cross-examine witnesses.

Process For Applications

12. Under the *Public Inquiry Act*, s. 11(3), I am permitted to require applicants for participation to apply "in the manner and form" that I indicate.

13. The Government announced the Terms of Reference for this Commission of Inquiry in August, 2007. In September, advertisements were placed in newspapers, and a press release was issued, calling for interested persons to apply if they wished to participate in the public hearings. Application packages were provided to anyone who requested them from the Commission's offices. Those packages described the Terms of Reference, s. 11(4) of the *Public Inquiry Act*, *supra*, and the mechanics of submitting an application. Applicants were asked to describe themselves and their proposed involvement, and to address the criteria in s. 11(4).

14. The Commission received a total of 13 applications from these agencies and individuals:

    1. British Columbia Ambulance Service;
    2. Vancouver Police Department and Vancouver Police Board (both represented by the same counsel);
    3. British Columbia Coroners Service;
    4. Office of the Police Complaint Commissioner ("OPCC");
    5. Criminal Justice Branch of the Ministry of Attorney General;
    6. the family of Frank Paul;
    7. Aboriginal Legal Services of Toronto;
    8. British Columbia Civil Liberties Association;
    9. First Nations Leadership Council;
    10. United Native Nations Society;

11. Thomas Allen Calder;
12. Julia C. George; and
13. Mark Watamaniuk.

15. In the discussion that follows, I will employ the numbering given above, and will discuss various applicants together where doing so is appropriate.

Analysis

Applicants 1–6

16. In the context of the *Public Inquiry Act*, *supra*, the considerations for a grant of participant status are expressly given in s. 11(4). To repeat, the three listed factors are: (1) whether the person's interests may be affected; (2) whether their participation would further the conduct of the inquiry; and (3) whether their participation would contribute to the fairness of the inquiry.

17. It is not difficult to reach a conclusion with respect to the first five applicants—the Ambulance Service; Vancouver Police Department and Board; the Coroners Service; the OPCC; and the Criminal Justice Branch. One need only read the Terms of Reference to see that their response to the death of Mr. Paul is to be part of my findings of fact in this matter. Furthermore, I am to examine the rules, policies and procedures of these agencies, and to offer recommendations for change if necessary.

18. These five applicants' interests are all directly affected (the first criterion). Including them in this Commission of Inquiry will, I believe, contribute to the fairness of the inquiry (the third criterion), as it will permit each of them the opportunity to become involved both in determining what occurred, and in speaking to the policy issues arising. The "fairness" criterion may be put the opposite way as well: it would not contribute to the fairness of this inquiry were one of these bodies excluded from participating. As to the second criterion, having reviewed their submissions in support of participation, I am confident that each of these agencies' participation will further the conduct of this inquiry.

19. The sixth listed applicant is the Paul family. The Paul family is not analogous to the first five agencies, because its conduct is not in issue (as is the case for the agencies). Yet while it does not face the prospect of having its behaviour evaluated, it cannot be denied that the Paul family has a true interest in

determining exactly what led to Mr. Paul's death. No doubt this is why the Province included mention of the Paul family in the Terms of Reference. In ss. (a), this Commission's statement of purpose is stated thus:

> (a) to provide Mr. Paul's family and the public with a complete record of the circumstances relating to Mr. Paul's death [emphasis added].

20. Would the Paul family's participation further the conduct of the inquiry and contribute to the fairness of the inquiry? I conclude that the answer to both questions is yes. The Paul family may play an important role in providing information to the Commission, although counsel for the Paul family does not suggest that he has additional direct evidence with respect to the events of December 5–6, 1998. Likewise, Mr. Paul's family may assist this Commission by ensuring that the family's concerns are properly represented through the course of the hearings. It may be that counsel for the Paul family approaches evidentiary and policy issues quite differently from counsel for the five agencies discussed above.

21. As to the extent of the participation of the five agencies and the Paul family, as the Act makes clear (ss. 11–13), I may make orders respecting the manner and extent of a participant's participation. These participants may attend the hearings, receive disclosure of records (according to the Commission's procedural rules), and make submissions. I will decide at a later date the extent to which counsel for these participants may call witnesses and/or cross-examine witnesses.

Applicants 7–10

22. I turn next to the applicants listed as numbers 7–10, Aboriginal Legal Services of Toronto; the British Columbia Civil Liberties Association; the First Nations Leadership Council; and United Native Nations.

23. Aboriginal Legal Services of Toronto ("ALST") was established to assist the Aboriginal community in influencing and exercising control over justice-related issues and factors that affect them. ALST has a background in the treatment of First Nations individuals by the justice system, including involvement as an intervener in nine cases before the Supreme Court of Canada. It has been involved in coroner's inquests in Ontario in situations where the deceased had

been intoxicated and came into contact with police and ambulance services immediately prior to their death.

24. The British Columbia Civil Liberties Association ("BCCLA") is a non-profit, non-partisan advocacy group founded in 1963, which focuses on protecting the rights of citizens to liberty and freedom. The BCCLA has a background of involvement in the issue of police oversight and accountability, in particular with the provincial *Police Act* (which applies to the Vancouver Police Department).

25. The First Nations Leadership Council is made up of three groups—the British Columbia Assembly of First Nations; the First Nations Summit; and the Union of BC Indian Chiefs. The Council was formed in 2005 to represent First Nations in their dealings with the Crown. The Council collectively represents First Nations communities and citizens throughout the province, both on and off reserves. It recently convened a First Nations Justice Forum, which focused on the over-representation of First Nations people in the criminal justice system.

26. United Native Nations Society ("UNNS") indicates that its application would be supported by a coalition of 12 Vancouver-based urban Aboriginal agencies. UNNS is an Aboriginal organization that represents the socio-economic and cultural interests of off-reserve Aboriginal people in the province, both rural and urban. It was established in 1969 and has a membership of approximately 40,500 members. UNNS provides referrals and advocacy for individuals seeking health care and social service programs in Vancouver, and as such has familiarity with these services.

27. UNNS applied not only for participant status, but also for funding. Nothing in the *Public Inquiry Act* gives me the authority to make an order that a participant receive public funding. There is some authority suggesting that I may nonetheless make a recommendation that such funding be provided: see *Jones v. Canada (R.C.M.P. Complaints Commissioner)* (1998), 162 D.L.R. (4th) 750 (Fed. T.D.) and *Berg v. British Columbia (Police Complaint Commissioner)*, 2006 B.C.C.A. 225. Assuming that I do have such a discretion, I decline to exercise it in respect of the UNNS's request.

28. There are differences among these four applicants, as to the extent to which their individual interests may be affected. ALST, being a Toronto organization, is in a different position than, for instance, the United Native Nations Society, which is based in Vancouver's Downtown Eastside. Yet despite differences, in my view all

four organizations present as strong applicants. Each has distinctive perspectives and input to bring to the proceedings, and I feel that each of these applicants would further the inquiry's conduct and contribute to its fairness. Each of these applicants has submitted detailed submissions in support of its participation, and is (or will be) represented by counsel; I expect that their involvement will be substantive, relevant, and responsible.

29. As such, I accept these four applicants as participants in the Commission of Inquiry.

30. I will decide at a later date the extent to which counsel for these participants may call witnesses and/or cross-examine witnesses.

Applicants 11–13

31. The final three applicants are individuals—Thomas Allen Calder; Julia C. George; and Mark Watamaniuk. I will deal with each in turn, applying the criteria set out in s. 11(4) of the *Public Inquiry Act*.

32. Mr. Calder asks to participate in a personal capacity. He does not have any involvement with the facts of this matter, and indicates that he has never met Mr. Paul. Mr. Calder has outlined his background, but in my view it is not relevant to the inquiry that this Commission must make. Having reviewed his application, I decline to grant him participant status.

33. Ms. George also applies in her personal capacity, and describes her background working with First Nations in many fields, including "land, law, rights, residential school," and as a liaison between First Nations and government and law officials. I do not understand her to have any factual involvement with Mr. Paul's case, and have concluded that Ms. George will not be granted participant status, as she is not in the position of a party whose interests may be affected by the Commission's findings; and I do not believe that her formal involvement would further the conduct of the inquiry or contribute to its fairness.

34. Ms. George has set out proposed questions for the police officers who were involved with Mr. Paul, along with her views on policy matters. Commission Counsel have been made aware of Ms. George's input.

35. Mr. Watamaniuk likewise appears in a personal capacity. Having reviewed his application materials, I cannot conclude (1) that his interests are affected; (2)

that his participation would further the conduct of the inquiry or (3) that it would contribute to the fairness of the inquiry. I decline to grant him participant status.

36. These three individual applicants are, of course, welcome to attend the public hearings, just as any member of the public may (which is to say, subject to the ordinary rules that apply to those in attendance).

_____

Commissioner W. Davies, Q.C.
Frank Paul Inquiry

Appendix G

RULING #2
Further Applications for Participant Status
November 26, 2007

THE FRANK PAUL INQUIRY
WILLIAM H. DAVIES, Q.C., COMMISSIONER
APPOINTED UNDER THE PUBLIC INQUIRY ACT,
S.B.C. 2007, C. 9

Introduction

1. On October 17, 2007, I made my first ruling on applications for participant status. That Ruling is available on the Inquiry website: **www.frankpaulinquiry.ca**.

Further applications

2. Since then, the Inquiry has received two further applications for participant status, made by counsel acting for former Sgt. Russell Sanderson and by counsel acting for Cst. David Instant, both of the Vancouver Police Department. Both applications are made after the deadline stated in the public call for participants. However, both applicants were at the relevant time members of the Vancouver Police Department that has been granted participant status.

Legislation

3. Subsection 11(4) of the *Public Inquiry Act* states:

   On receiving an application under subsection (3), a commission may accept the applicant as a participant after considering all of the following:

   (a) whether, and to what extent, the person's interests may be affected by the findings of the commission;

(b) whether the person's participation would further the conduct of the inquiry;

(c) whether the person's participation would contribute to the fairness of the inquiry.

4. These are the criteria that have guided my analysis and determination of who should be accepted as participants for this Commission of Inquiry.

5. As I stated in Ruling #1, the legislation does not specify what rights may be granted to participants, but it is uncontroversial to say that participation would typically include access to documents (according to the commission's procedural rules); a seat at counsel table; and the opportunity to make closing submissions. Depending on the extent of participation authorized, a participant might or might not be permitted to apply to call witnesses or suggest what witnesses should be called; and might or might not be permitted to cross-examine witnesses.

Analysis

Application by Russell Sanderson

6. It is not disputed that on the evening of December 5, 1998, Sgt. Sanderson was the sergeant on duty in the Vancouver Police Department Jail at 312 Main Street, when Mr. Paul was brought in.

7. Mr. Sanderson played a significant role in the events of December 5, 1998, which this Inquiry will be examining. Subsequently, he was the subject of disciplinary proceedings within the Vancouver Police Department, respecting his conduct on that evening. It is apparent from the opening statement of the Department that a divergence of positions exists as between the Department and Mr. Sanderson.

8. I am satisfied that Mr. Sanderson should be accepted as a participant, for the following reasons:

   - His interests may be affected by the findings of the Commission, within the meaning of s. 11(4)(a) of the Act, and

   - His participation would contribute to the fairness of the inquiry, within the meaning of s. 11(4)(c) of the Act. His decision to retain counsel other

than counsel who represents the Vancouver Police Department is reasonable in view of the Department's stated position.

9. As to the extent of Mr. Sanderson's participation, as the Act makes clear (sections 11–13), I may make orders respecting the manner and extent of a participant's participation. Mr. Sanderson may attend the hearings, receive disclosure of records (according to the commission's procedural rules), and make submissions. I will decide at a later date the extent to which counsel for Mr. Sanderson may call witnesses and/or cross-examine witnesses.

Application by David Instant

10. On the evening of December 5, 1998, Cst. Instant was the driver of the Vancouver Police Department police wagon.

11. Mr. Instant played a significant role in the events of December 5, 1998, which this Inquiry will be examining. Subsequently, he was the subject of disciplinary proceedings within the Vancouver Police Department, respecting his conduct on that evening.

12. I am satisfied that Mr. Instant should be accepted as a participant, for the following reasons:

    - His interests may be affected by the findings of the Commission, within the meaning of s. 11(4)(a) of the Act, and

    - His participation would contribute to the fairness of the inquiry, within the meaning of s. 11(4)(c) of the Act. His decision to retain counsel other than counsel who represents the Vancouver Police Department suggests that his interests may differ from those of the Department. If that is so, it is important that Mr. Instant's interests be separately represented before the Inquiry.

13. As to the extent of Mr. Instant's participation, as the Act makes clear (sections 11–13), I may make orders respecting the manner and extent of a participant's participation. Mr. Instant may attend the hearings, receive disclosure of records (according to the commission's procedural rules), and make submissions. I will decide at a later date the extent to which counsel for Mr. Instant may call witnesses and/or cross-examine witnesses.

_____
Commissioner W. Davies, Q.C.
Frank Paul Inquiry

Appendix H

RULING #3

Participant Status of

Police Complaint Commissioners

January 29, 2008

THE FRANK PAUL INQUIRY
WILLIAM H. DAVIES, Q.C., COMMISSIONER
APPOINTED UNDER THE PUBLIC INQUIRY ACT,
S.B.C. 2007, C. 9

Commission Counsel: Geoffrey Cowper, Q.C.

Associate Commission Counsel: Brock Martland

Participant	Counsel
Aboriginal Legal Services of Toronto	Kimberly Murray and Jonathan Rudin
Ambulance Service/EHS Commission	Douglas Eastwood
Benjamin Casson	Terrence Robertson, Q.C.
BC Civil Liberties Association	Michael Tammen and Grace Pastine
BC Coroners Service	Rodrick MacKenzie
Criminal Justice Branch, Ministry of Attorney General	Richard Peck, Q.C., and Tim Hinkson

Participant	Counsel
First Nations Leadership Council	Steven Kelliher
David Instant	David Crossin, Q.C.
Don Morrison	Joseph Arvay, Q.C.
Paul Family	Steven Kelliher
Police Complaint Commissioner (Ryneveld)	Frank Falzon
Russell Sanderson	Kevin Woodall
United Native Nations Society	Cameron Ward and David Eby
Vancouver Police Department and Vancouver Police Board	George Macintosh, Q.C., and Sean Hern

Introduction

1. On October 17 and on November 26, 2007, I made my first two Rulings on applications for participant status. Those Rulings are available on the Inquiry website: www.frankpaulinquiry.ca.

Further applications

2. In my first Ruling, I granted participant status to the Office of the Police Complaint Commissioner. Since then, I have been made aware of several changes in circumstances, which necessitate a reconsideration of that aspect of my first Ruling:

- the current Police Complaint Commissioner is Mr. Ryneveld. His counsel (Mr. Falzon) has advised Commission Counsel that there is at law no office known as "The Office of the Police Complaint Commissioner." Rather, the *Police Act* refers only to the "Commissioner" in a personal sense. Consequently, he takes the position that he acts only for the current Commissioner, Mr. Ryneveld, and he has advised the former Commissioners to that effect.

- Three other individuals held the office of Commissioner prior to Mr. Ryneveld. In order of appointment, they are Mr. Donald Morrison, Ms. Barbara Murphy and Mr. Benjamin Casson. Messrs. Morrison and Casson now seek full participant status for Phase 2 of this Inquiry's proceedings.

3. For convenience, I have divided the Inquiry's proceedings into various Phases. Phase 2 relates to paragraph (b) of the Terms of Reference, which states:

> (b) to make findings of fact regarding circumstances relating to Mr. Paul's death, including findings of fact respecting the response of British Columbia Ambulance Service, the Vancouver Police Department, the BC Coroners Service, the Office of the Police Complaints Commissioner and the Criminal Justice Branch of the Ministry of Attorney General to the death of Mr. Paul.

Legislation

4. Subsection 11(4) of the *Public Inquiry Act* states:

> On receiving an application under subsection (3), a commission may accept the applicant as a participant after considering all of the following:
>
> (a) whether, and to what extent, the person's interests may be affected by the findings of the commission;
>
> (b) whether the person's participation would further the conduct of the inquiry;
>
> (c) whether the person's participation would contribute to the fairness of the inquiry.

5. These are the criteria that have guided my analysis and determination of who should be accepted as participants for this Commission of Inquiry.

6. As I stated in Ruling #1, the legislation does not specify what rights may be granted to participants, but it is uncontroversial to say that participation would typically include access to documents (according to the commission's procedural rules); a seat at counsel table; and the opportunity to make closing submissions. Depending on the extent of participation authorized, a participant might or might not be permitted to apply to call witnesses or suggest what witnesses should be called; and might or might not be permitted to cross-examine witnesses.

Analysis

The current Commissioner, Mr. Ryneveld

7. For the reasons stated in my first Ruling (see para. 18), I am satisfied that the interests of the current Commissioner are directly affected (the first statutory criterion), that his participation will further the conduct of the inquiry (the second criterion) and that his participation will contribute to the fairness of the inquiry (the third criterion).

8. However, in light of Mr. Falzon's assertion that there is at law no "Office", and that each Commissioner's position is of a personal nature, I have concluded that the current Commissioner's participant status should be restricted as follows:

- During Phase 2, the current Commissioner is granted participant status respecting only those matters that relate to or arise out of his tenure as Commissioner,
- During Phase 4 (which will involve an examination of the rules, policies and procedures of several public bodies, including the Police Complaint Commissioner), the current Commissioner is granted participant status as it relates to his role as Commissioner.

Applications by former Commissioners Morrison and Casson

9. I am satisfied that the interests of each of these two former Commissioners are directly affected (the first statutory criterion), that his participation will further the conduct of the inquiry (the second criterion) and that his participation will contribute to the fairness of the inquiry (the third criterion).

10. However, I have concluded that the participation of each of these two former Commissioners should be restricted to those matters that relate to or arise out of his tenure as Commissioner.

11. If either or both of these former Commissioners would like to make representations or submissions during Phase 4, I invite them to contact Commission Counsel.

Extent of participation

12. As to the extent of the participation of the current Commissioner and of these two former Commissioners, as the Act makes clear (sections 11–13), I may make orders respecting the manner and extent of a participant's participation. They may, with respect to the matters to which their participation relates, attend the hearings, receive disclosure of records (according to the commission's procedural rules), and make submissions. I will decide at a later date the extent to which they may call witnesses and/or cross-examine witnesses.

Production of Police Complaint Commissioner documents

13. Commission Counsel requested documents from the Police Complaint Commissioner in late 2007. Commission Counsel has advised me that substantial production has been made as of today's date. If any further production is required, I request that it be done forthwith, so as not to prejudice the interests of other participants, and so as to ensure the timely conduct of the Phase 2 hearings.

_____
Commissioner W. Davies, Q.C.
Frank Paul Inquiry

Appendix I

RULING 4
The Inquiry's Authority to Inquire into the Response of the Criminal Justice Branch
February 27, 2008

FRANK PAUL INQUIRY
WILLIAM H. DAVIES, Q.C., COMMISSIONER
APPOINTED UNDER THE PUBLIC INQUIRY ACT,
S.B.C. 2007, C. 9

Preliminary Matters

Nature of the Application

1. This application is brought by the Criminal Justice Branch of the provincial Ministry of Attorney General, one of the participants in this Inquiry. The Branch's position is set out in para. 3 of its December 17, 2007 written submission, which states:

> It is submitted that the scope of the Inquiry's jurisdiction to inquire into the Criminal Justice Branch is, at law, limited to inquiring into information from Criminal Justice Branch officials that relates to the Charge Approval policy. The Paul Inquiry cannot inquire into legal advice given or received by Crown Counsel in the employ of the Criminal Justice Branch or the exercise of discretion in an individual case. Accordingly, the Crown cannot be subpoenaed to testify either at trial or at an inquiry about why a charge was laid, or not laid, in any given case, nor can documents relating to this function be ordered disclosed. This immunity flows from the constitutional principle of Crown independence and from the privilege that attaches to legal professional advice.

2. The Branch submits (para. 10) that I should interpret the Terms of Reference in accordance with the principles of Crown immunity and legal professional privilege, in the following ways, that:

   - No individual prosecutor involved in the Frank Paul case be subjected to questioning about his/her exercise of discretion in the case,
   - No representative of the Branch be questioned on matters relating to the exercise of discretion in this case,
   - The Branch provide a statement of the broad reasons for not prosecuting this matter, outlining the facts underlying the decisions, the process followed, and the standard applied, and
   - This statement be made in writing, or by way or oral evidence on oath, from an appropriate senior Branch official.

3. Before addressing the Branch's submission, I think that it is important to put this application into its proper historical context.

Precipitating events

4. On December 5, 1998, Frank Paul was taken into custody by officers of the Vancouver Police Department, for being in a state of intoxication in a public place. He was placed in the "drunk tank" and, a few hours later, was released.

5. Later that day he was again taken into custody for being in a state of intoxication in a public place. The driver of the police van (Cst. Instant) brought him to the police station. He took Mr. Paul, by elevator, to the fifth floor lockup. The officer in charge of the lockup (Sgt. Sanderson) decided not to accept Mr. Paul into the Jail, and directed Cst. Instant to return him to the police van and deliver him to the corner of Broadway Avenue and Maple Street, which was the area he was known to frequent.

6. After leaving the police station with Mr. Paul, Cst. Instant was informed by a senior police officer that Mr. Paul was homeless. Cst. Instant ultimately left Mr. Paul in an alleyway that led to the Vancouver Detox Centre.

7. Early the next morning a civilian found Mr. Paul's body in that same alleyway. The autopsy report attributed death to hypothermia due to acute alcohol intoxication.

8. In 2000 the Vancouver Police Department concluded disciplinary proceedings against two officers. Sgt. Sanderson was suspended for two days for discreditable conduct, and Cst. Instant was suspended for one day for neglect of duty.

9. No inquest was held under the *Coroners Act* into Mr. Paul's death, and no public hearing was ordered by the Police Complaint Commissioner under the *Police Act*.

10. According to the Branch's written submission (paras. 12 and 13), the Branch assessed whether there was sufficient evidence to proceed with charges against anyone relating to the death of Mr. Paul. Five separate opinions were sought, and in all five assessments the conclusion was the same: there was insufficient evidence to meet the criminal standard of proof beyond a reasonable doubt. All those assessments were reviewed by the Assistant Deputy Attorney General, who was and is in agreement that the available evidence was insufficient to proceed with criminal charges.

11. In June 2003 a subsequent Police Complaint Commissioner re-opened the Frank Paul file. In his January 2004 Reasons for Decision, he expressed the hope that the Chief Coroner or the Attorney General would be persuaded by the evidence to conduct either a Coroner's Inquest or a Public Inquiry. He recommended that a full public inquiry under the *Inquiry Act* would be preferable.

12. The Chief Coroner did not order an Inquest. The Solicitor General announced my appointment as sole Commissioner of this inquiry on March 9, 2007. This Commission of Inquiry was approved and ordered by the Lieutenant Governor in Council on August 9, 2007.

13. Although no evidence has been led on this point, I infer from this chronology that some individuals and/or organizations were unhappy with the manner in which Mr. Paul had been treated by the police, how he had died and how various public bodies had responded to his death. The March 9, 2007 Information Bulletin announcing my appointment supports that inference. It states in part:

Solicitor General John Les announced the inquiry on Feb. 22, 2007, in response to ongoing public concern and interest in the Frank Paul matter, and a need to ensure public confidence in the administration of justice.

Terms of Reference

14. Although paragraph (b) of the Terms of Reference is the principal focus of this application, it is necessary to understand this application in the broader context of the overall mandate of the Inquiry. For that reason, I will set out in full the Purpose and Terms of Reference:

Purpose:

(a) to provide Mr. Paul's family and the public with a complete record of the circumstances relating to Mr. Paul's death;

(b) to recommend changes considered necessary to the rules, policies and procedures referred to in section 4(c), (d) and (e).

Terms of reference:

(a) to conduct hearings, in or near the City of Vancouver, into the circumstances surrounding the death of Mr. Paul;

(b) to make findings of fact regarding circumstances relating to Mr. Paul's death, including findings of fact respecting the response of British Columbia Ambulance Service, the Vancouver Police Department, the BC Coroners Service, the Office of the Police Complaints Commissioner and the Criminal Justice Branch of the Ministry of Attorney General to the death of Mr. Paul;

(c) to examine the rules, policies and procedures of the Vancouver police board and of the Vancouver police department respecting police interaction with persons who are incapacitated by alcohol or drug use, including directions for the handling, detention, transportation and release of individuals who, as a result of alcohol or drug use, are incapacitated, violent, unable to care for themselves, self-destructive or unconscious;

(d) to examine the rules, policies and procedures of the British Columbia Ambulance Service respecting the interaction of staff of the British Columbia Ambulance Service with persons who are incapacitated by alcohol or drug use, including directions for the handling and transportation of individuals who, as a result of alcohol or drug use, are

incapacitated, violent, unable to care for themselves, self-destructive or unconscious;

(e) to examine the rules, policies and procedures of the BC Coroners Service, the Office of the Police Complaints Commissioner and the Criminal Justice Branch of the Ministry of Attorney General related to the role and response of each of those offices where an individual dies in circumstances similar to the circumstances of Mr. Paul's death;

(f) to recommend changes considered necessary to the rules, policies and procedures referred to in paragraphs (c), (d) and (e);

(g) to identify the health care and social service programs and facilities available in the City of Vancouver that the police may access if a municipal constable determines that a person should not be detained but the person requires immediate health care or social services because the person is incapacitated by alcohol or drug use;

(h) to submit a final report to the Attorney General on or before May 31, 2008.

15. The aspect of paragraph (b) applicable to the Branch can be stated as follows:

(b) to make findings of fact regarding circumstances relating to Mr. Paul's death, including findings of fact respecting the response of ... the Criminal Justice Branch of the Ministry of Attorney General to the death of Mr. Paul;

16. The Branch does not take issue with my jurisdiction to examine the rules, policies and procedures of the Criminal Justice Branch and to recommend changes considered necessary, pursuant to paras. (e) and (f) of the Terms of Reference.

Positions of the Parties on this Application

Criminal Justice Branch

17. The Attorney General's discretion relating to the institution of prosecutions springs from the Royal prerogative. The exercise of the Crown's discretion in an individual case, to either commence or terminate proceedings, is generally immune from any form of judicial or executive review. In British Columbia the Attorney General has a dual role. As the chief law officer of the Crown, he or she has an independent responsibility to consider, objectively and independently of

partisan concerns, what actions (including criminal prosecutions) must be taken to uphold the rule of law. However, as an elected member of the Legislative Assembly and an active member of a political party, the Attorney General lacks the independence traditionally inherent in the office.

18. In order to preserve the independence of the Crown in conducting prosecutions, B.C. enacted the *Crown Counsel Act*, R.S.B.C. 1996, c. 87, which provides individual Crown Counsel with a barrier from political interference. Section 4(3)(a) provides that each Crown Counsel is authorized to "examine all relevant information and documents and, following the examination, to approve for prosecution any offence or offences that he or she considers appropriate." Under s. 5, the Attorney General or Deputy Attorney General may give a direction with respect to the approval or conduct of any specific prosecution only if the direction is in writing and published in the Gazette.

19. In *Krieger v. Law Society of Alberta* (2002), 168 C.C.C. (3d) 97 (S.C.C.), the Court stated in part (at para. 45):

> A decision of the Attorney General ... within the authority delegated to him or her by the sovereign is not subject to interference by other arms of government. An exercise of prosecutorial discretion will, therefore, be treated with deference by the courts and by other members of the executive, as well as statutory bodies like provincial law societies.

20. The Court then enumerated the five core elements of prosecutorial discretion:

- The discretion whether to bring the prosecution of a charge laid by police,
- The discretion to enter a stay of proceedings,
- The discretion to accept a guilty plea to a lesser charge,
- The discretion to withdraw from criminal proceedings altogether, and
- The discretion to take control of a private prosecution.

21. The Branch submits that Crown immunity prevents any inquiry into core exercises of prosecutorial discretion in a particular case, and that the immunity principle is a complete bar to any such inquiry, subject to an abuse of process exception. The common law principle of Crown immunity has now been accorded

a constitutional status (*Krieger*), and the continued vitality of a strong and independent justice system depends on the notion that each group of actors within the system be able to exercise their role free from outside influence, political or otherwise. Crown independence and objectivity has its home in s. 7 of the Charter, which entitles an accused to independence and objectivity in the Crown's exercise of its discretion to prosecute.

22. According to the Branch, the quasi-judicial function of the Attorney General cannot be subjected to interference from parties who are not as competent to consider the various factors involved in making a decision to prosecute. To subject such decisions to political interference, or to judicial supervision, could erode the integrity of our system of prosecution (*Krieger*). Since this immunity applies to courts, other members of the executive and statutory bodies, this Inquiry (which is a statutory, quasi-judicial body established by and reporting to the executive) engages both the judicial and political aspects of review that are not permitted.

23. The Branch also submits that the calling of a prosecutor to testify on the issue of charge approval at an Inquiry engages the same principles (judicial independence) that, in *MacKeigan v. Hickman*, [1989] 2 S.C.R. 796 (S.C.C.), were held to prohibit the calling of such evidence.

24. Also, according to the Branch, Crown immunity cannot be waived, once it has been raised, absent an evidentiary foundation for an allegation of abuse of process. Even where the Crown has not raised an objection, disclosure should be prohibited if it would be harmful to the public interest. The immunity applies to all reports and other documents, the disclosure of which may damage the process of Crown decision-making. Subjecting the exercise of prosecutorial discretion to ex post facto reviews by outside parties, particularly Inquiries struck by the executive, creates several risks:

- It threatens to give rise to inappropriately high charge approval rates,
- It may subject witnesses and complainants to undue public attention and scrutiny for making reports to police in circumstances where charges are not approved, and

- Governmental, political and public scrutiny, applied through a public inquiry, would subject prosecutorial discretion to political interests.

25. Turning to the *Public Inquiry Act*, the Branch draws attention to:

- s. 13(2)(a), which provides that a participant "has the same immunities as a witness who appears before the court,"
- s. 22(2), which provides that: "A person cannot be compelled to disclose to a hearing commission anything that, in any court, would be privileged under the law of evidence," and
- s. 29(1), which provides that: "If the government discloses to a commission, either voluntarily or in response to a request or summons, any information over which the government asserts privilege or immunity, the privilege or immunity is not waived or defeated for any other purpose by the disclosure."

26. Further, according to the Branch, the Legislative Assembly has indicated a clear intention to require that Inquiries respect common law immunities (including immunity from review of Crown discretion to commence or terminate a prosecution) and privileges (including legal professional privilege). Further, that section 29 makes it clear that the government may disclose certain information to a Commission and maintain its privileges and immunities, but clearly anticipates that there will be instances when the government does not, by virtue of the modifier "If." Any ambiguity should be resolved in favour of preserving the immunity and privilege.

27. With respect to the Purposes and Terms of Reference for this Inquiry, the Ministry submits that the way to read Term of Reference (b) in a way that is harmonious with the two Purposes, is that the Criminal Justice Branch's "response" to Mr. Paul's death relates to Purpose (b); namely, has the Branch responded in a way that develops satisfactory rules, policies and procedures in relation to a death of this kind? This interpretation avoids any constitutional conflict. However, if I conclude that "response" unambiguously refers to the exercise of prosecutorial discretion, then an issue of ultra vires arises, in that Cabinet has directed an inquiry into Crown discretion, immunity and independence, which Cabinet has no constitutional authority to do.

28. During oral argument, counsel for the Ministry clarified that the core area of prosecutorial discretion that is immune from review by this Commission of Inquiry is "the charge/no charge decision" (January 18, 2008, p. 168) and "the basis for a proper charge" (p. 169). Counsel stated that this Inquiry is precluded from "second-guessing that judgement call" (p. 169). He also gave examples of the types of information and documents that are "fair game to look at" (p. 169), including the following:

    - Communications between the Crown and police about investigative steps that need to be taken,
    - The Crown's involvement in the investigation,
    - How thorough the investigation was,
    - What are the facts that were assembled by the police and deposited with the Crown for their assessment,
    - What the body of evidence was that the police ultimately assembled for the Crown's consideration,
    - What directions the Crown gave the police, or what investigative steps the Crown told the police to take,
    - What policies were in place, and whether the Crown followed those policies, and
    - Why an independent prosecutor was not appointed.

29. Counsel for the Ministry added that:

    - it would produce any documents other than the short list of documents that the Ministry submits come within the charge–no charge decision, and
    - it would produce someone knowledgeable about the case, who would be subject to cross-examination about the thoroughness of Crown Counsel and the police conduct in the matter, without trenching on the core of the discretion.

30. However, the Ministry stated that it would not produce two of the former prosecutors who made charge assessment decisions in the Frank Paul matter

(Messrs. Cullen and Hicks), both of whom are now judges. According to the Ministry, they are completely immune from subpoena as a result of being judges.

31. At my request, counsel for the Ministry provided the Inquiry with a letter setting out specifically what information the Criminal Justice Branch was prepared to provide to the Commission and who, on behalf of the Branch, would be prepared to come forward as a witness before the Commission. Counsel's January 25, 2008 letter states in part:

> (a) The Criminal Justice Branch is prepared to provide to the Commission a statement in writing (to be read into the Record by [Mr. Peck] or Mr. Code, and to be filed with the Commission), generally outlining the reasons for not proceeding with a prosecution in the Frank Paul matter.
>
> (b) To present to the Commission as a witness, Mr. Greg Fitch, Q.C., Director, Criminal Appeals and Special Prosecutions, to speak to the Criminal Justice Branch policies and procedures in place at the various times of the charge approval decisions in this case, whether those policies and procedures were followed, and what current policies and procedures are in place. In addition, and as we submitted, questions about investigative steps taken by the police on the Crown's advice, or any investigative steps not taken, as well as questions about the fruits of the investigation that were eventually produced by the police to the Crown, are not covered by the core Crown immunity and could be the subject of testimony. Questions about the various decisions not to prosecute, or how the fruits of the investigation impacted, or could impact, on those decisions, or any hypotheticals related thereto, are within the core Crown immunity and cannot be the subject to testimony.
>
> (c) ... It would have to be understood and agreed that, at the time of his questioning under oath, Mr. Fitch would not be subjected to any questioning touching upon the exercise of Crown discretion in the charge approval process specific to this case, including not being subjected to questioning arising from any hypothetical fact pattern.

32. Later in this Ruling I will summarize the Branch's position respecting solicitor-client and litigation privilege.

Commission Counsel

33. Commission Counsel takes no issue with the general principle established in *Krieger* that prosecutorial independence requires that quasi-judicial functions of the Attorney General and Crown Counsel must be free from political interference and judicial supervision. However, he argues that Crown immunity does not shield Crown Counsel from a claim for malicious prosecution or from a law society's investigation of a prosecutor's breach of ethical standards, and further that there is no judicial decision addressing the narrow question of the application of Crown immunity to review of prosecutorial discretion by a Commission of Inquiry.

34. Further, that a Commission of Inquiry is not a court or a statutory tribunal. It has no authority to determine legal liability. Once established, it operates independently from the executive branch of government. Its role is to investigate an issue or an event, but it has no power to interfere in decisions that have been made. A Commission of Inquiry is sufficiently independent of the executive for the commission, as an institution, to deal with issues that cannot be addressed by the executive for fear that political interference would result, or appear to result.

35. If the Branch's assertions are correct then the Commission will be unable to properly answer the question of the response of the Branch to the death of Frank Paul.

36. According to Commission Counsel, a Commission of Inquiry is not a statutory tribunal as normally understood, because it has no decision-making authority. The tribunals in all cases relied on by the Branch had statutory power to make legal findings of fault, or findings with legal consequences, enforceable on those involved.

37. In the absence of legal authority on whether Crown immunity should extend to commissions of inquiry, the best guidance ought to lie in the history of commissions of inquiry dealing with this issue. According to Commission Counsel, the non-application of Crown immunity to commissions of inquiry is recognized, at least implicitly, in the tradition of these inquiries:

- The Discretion to Prosecute Inquiry (the "Reid Inquiry"),

- The Royal Commission of Inquiry into Certain Deaths at the Hospital for Sick Children (the "Nelles Inquiry"),
- The Inquiry into Certain Aspects of the Trial and Conviction of James Driskell,
- The Cornwall Public Inquiry,
- The Royal Commission on the Donald Marshall, Jr. Prosecution, and
- Inquiry Regarding Thomas Sophonow.

38. Commission Counsel submits that several of these commissions inquired into exercises of prosecutorial discretion in its "core" sense, and the reports from the others indicate that they came very close to doing so. In none does it appear that Crown immunity was raised.

39. The rationales supporting the principle of prosecutorial independence relate to immunizing it from judicial review or political interference; it exists to ensure the public interest and confidence in a professional, impartial and independent administration of the state's critical role in prosecuting crime. Exempting Crown Counsel from review by a public inquiry with Terms of Reference to inquire into how the Criminal Justice Branch responded to a specific situation would defeat the purpose for the creation of the Inquiry by the Lieutenant Governor in Council.

40. The reasons why prosecutorial discretion should be immune from judicial review do not apply to a public inquiry—a public inquiry is not a court (and consequently does not blur the functions of prosecutors and judges); it does not make a legal determination of a matter; its findings are not binding on anyone and it does not establish judicial precedents with which Crown Counsel would have to contend in future cases.

41. Commission Counsel submits that *MacKeigan* was concerned with the separation of powers between the judicial and executive branches of government. No such separation of powers argument applies in the present case, as both Crown prosecutors and the Commission of Inquiry are, for their own parts, agents of the executive branch.

42. According to Commission Counsel, the Discretion to Prosecute Inquiry (the "Reid Inquiry") serves as a model of clarity, which could serve as a template for this Inquiry. It was authorized to inquire into the process and procedure followed by the Ministry of Attorney General in deciding not to prosecute Mr. Reid, including:

- The correctness and adequacy of the process applied in making that decision,
- The objectivity and good faith with which the process was carried out,
- The presence or absence of external influence affecting the decision, and
- The integrity with which the decision was made.

43. With respect to the *Public Inquiry Act*, Commission Counsel submits that s. 13(2) does not contemplate an immunity in the nature of Crown immunity, but rather confirms that "use" immunity will apply to the testimony of participants.

44. Commission Counsel submits that Crown immunity does not apply to the Commission of Inquiry but, if it does, the Executive Branch has determined (as evidenced by the Order in Council establishing the Commission and by the Terms of Reference), that disclosure would not be contrary to the public interest, but would in fact be in the public interest as a means for the Branch to answer questions raised as to its handling of the matter.

45. With respect to the Purposes and Terms of Reference of this Inquiry, Commission Counsel submits that Term of Reference (b) unambiguously requires that I make findings of fact respecting the Criminal Justice Branch's exercise of prosecutorial discretion in the Frank Paul matter, and that Terms of Reference (e) and (f) deal with the completely separate issue of the adequacy of the Branch's current rules, policies and procedures.

Solicitor-Client Privilege

46. In its written submissions, the Branch submitted (paras. 105 and 109) that all documents and correspondence generated by Crown Counsel and provided to the Assistant Deputy Attorney General in relation to the five charge approval reviews constitute legal advice to the Assistant Deputy about whether or not to commence

criminal proceedings and are not subject to disclosure, because of solicitor-client privilege and work product privilege: *R. v. Shirose* (1999), 133 C.C.C. (3d) 257 (S.C.C.); *Idziak v. Canada (Minister of Justice)* (1992), 77 C.C.C. (3d) 65 (S.C.C.); *R. v. Millar*, [2002] B.C.J. No. 2013 (B.C.S.C.); *R. v. Brown [Disclosure]*, [1997] O.J. No. 6163 (Ont. C. J.).

47. Counsel for the Ministry has filed a list of documents that identifies 12 documents in relation to which the Ministry does not claim privilege, and 23 specific documents and three categories of documents in relation to which it does claim privilege.

48. Although documents relating to the charge assessment decisions have not been tendered and testimony about the processes followed has not been heard, I have some understanding of the sequence of events, drawn from Commission Counsel's written Supplemental Response and from counsel for the Branch's written Reply Submissions:

- First charge assessment–on May 11, 1999, the VPD Major Crime Section's Report to Crown Counsel prepared by Det. Staunton was forwarded to Regional Crown Counsel, who requested certain follow-up information from VPD, which was responded to in September 1999. Regional Crown Counsel conducted the charge assessment in November 1999, and the no-charge decision was communicated to the Branch's Director of Legal Services.

- Second charge assessment–the Branch's Director of Legal Services conducted a second charge assessment in December 1999. The Branch's charge approval policy required this review in cases where a Report to Crown Counsel contains allegations against a peace officer. This assessment involved the preparation of a legal memorandum from an individual Crown Counsel to the Director. The Director's no-charge decision was communicated to the acting Regional Crown Counsel and, as required by Branch policy, to the acting Assistant Deputy Attorney General. On December 21, 1999, the acting Regional Crown Counsel wrote a letter to Insp. Biddlecombe of VPD, advising of the no-charge decision and the reasons for it. The letter was subsequently widely distributed.

- Third charge assessment–in December 2000 the Police Complaint Commissioner advised the Branch of his intention to review the investigation of the complaints against the police officers. The results of that review were forwarded to the Assistant Deputy, who forwarded them to the Branch's Director of Legal Services, who conducted a third charge

assessment. This assessment involved the preparation of a legal memorandum from an individual Crown Counsel to the Director. The Director's no-charge decision was communicated to the Regional Crown Counsel. Documentation on the file also indicates the Director's intention to communicate his opinion to the Assistant Deputy, as required by Branch policy. The decision was communicated to the Police Complaint Commissioner in August 2001.

- Fourth charge assessment–in March 2004 Regional Crown Counsel conducted a fourth charge assessment, in light of additional information provided by the Police Complaint Commissioner. In April 2004 Regional Crown Counsel reported to the Assistant Deputy Attorney General that the new information did not affect the earlier no-charge decision.

- Fifth charge assessment–in April 2004 the Assistant Deputy Attorney General retained a former Director of Legal Services, who had conducted one of the earlier assessments, to conduct a fifth charge assessment. This assessment consisted of a comprehensive review of the investigative materials, including all the new information assembled by the Police Complaint Commissioner. In June 2004 the former Director's no-charge decision (that also expressed the opinion that the previous four assessment decisions were correct) was communicated to the Assistant Deputy Attorney General, as required by Branch policy.

- Reviews by Assistant Deputy Attorney General–the Assistant Deputy Attorney General reviewed all the charge assessments at various times, and agreed with the decisions that the available evidence was insufficient to proceed with criminal charges.

49. In his Supplemental Response, Commission Counsel submits that a claim of solicitor-client privilege is premised on the existence of a solicitor-client relationship, and the provision of legal advice to the client. The first four charge assessment decisions do not constitute legal advice, because each prosecutor was exercising an independent statutory authority to decide whether or not a prosecution would be brought. He did not press for disclosure of the fifth charge assessment, as it appeared to include an element of administrative review respecting the correctness of the four earlier decisions, and to constitute advice to the Assistant Deputy. He added that the reviews by the Assistant Deputy Attorney General may be seen to constitute internal administrative reviews as to the adequacy of previous decisions made by the Branch.

50. Commission Counsel submits, in the alternative, that if solicitor-client privilege applies in the circumstances, the Executive as the ultimate client has waived it either expressly or by implication through its Terms of Reference, that instruct me to inquire into the Branch's "response" to Mr. Paul's death. Finally, work product privilege expires "with the litigation of which it was born" (*Blank v. Canada*, [2006] S.C.R. 319 at para. 8). If work product privilege ever did apply to the charge assessment review process, it has long since expired.

51. In the Branch's written Reply Submissions, counsel submits that the statutory and policy framework for the Criminal Justice Branch clearly contemplates that legal advice is intended to flow from Crown Counsel up through senior Branch members, including the Director, for the ultimate consideration of the Assistant Deputy Attorney General, who has the ultimate authority over charge approval. Consequently, a solicitor-client relationship does exist, and thus solicitor-client privilege attaches to the documents in question.

52. The Branch further submits that given this statutory and policy framework, the Branch is the client, and thus the Branch is the holder of the solicitor-client privilege under consideration. The Branch has not waived privilege over the documents in question, and neither has the Attorney General directed the Assistant Deputy Attorney General to do so, under s. 6 of the *Crown Counsel Act*. Even if the Lieutenant Governor in Council had the authority to waive privilege, the general language of the Terms of Reference does not indicate an intention to do so. In any event, it conflicts with the specific preservation of privilege found in s. 22 of the *Public Inquiry Act*. Further, the circumstances required to establish an implied waiver do not exist in this case.

53. Finally, the Branch submits that distribution of Mr. Hicks' letter to the VPD is protected by common interest privilege, and the letter's subsequent circulation was either unauthorized or inadvertent, neither of which amounts to waiver.

Other Participants

Aboriginal Legal Services of Toronto (ALST)

54. ALST adopted the argument advanced by Commission Counsel.

55. Counsel for this participant argued that if I conclude that Crown immunity does apply in the context of a public inquiry, it does not and ought not to apply specifically to this Inquiry—an inquiry examining the death of an Aboriginal person. This is because I must give heed to the honour of the Crown when assessing whether the Branch can be insulated from the mandate of this Inquiry. Relying on the honour of the Crown requires that I take notice of the findings of courts and previous commissions of inquiry, that systemic discrimination exists against Aboriginal people generally, and specifically that the criminal justice system has failed Aboriginal people.

56. ALST submits that the honour of the Crown is always at stake when dealing with Aboriginal people (*R. v. Badger*, [1996] 2 C.N.L.R. 77 (S.C.C.)), and that the honour of the Crown cannot be interpreted narrowly or technically, but must be given full effect in order to promote the process of reconciliation. There can be no meaningful reconciliation without the Aboriginal community being satisfied that all relevant information has been provided to this Inquiry.

57. In interpreting the honour of the Crown broadly, it is important that the systemic discrimination faced by Aboriginal people as a result of the acts of the Crown be recognized; in particular, the impact of the discriminatory application and effects of the criminal justice system.

58. The role of the Branch in determining whether criminal charges should be laid in response to Frank Paul's death has been, and continues to be, a concern to the Aboriginal community. Would charges have been laid if Frank Paul were not an Aboriginal person? In order to allay the understandable concerns of the Aboriginal community respecting the Branch's response, a full review of its decisions is required. The Branch's proposal to make a statement is a totally inadequate response. Without examining the Branch's role in this matter, the honour of the Crown to Aboriginal people will not be served.

United Native Nations Society (UNNS)

59. UNNS adopts the submissions of Commission Counsel.

60. In addition, UNNS submits that it is incongruous that the Attorney General would on the one hand announce Terms of Reference prescribing that the actions

of the Branch be fully explored and, on the other hand, instruct counsel to seek a direction that the Branch be immune from such an examination.

61. To the Aboriginal community represented by UNNS, Frank Paul's case is symbolic of serious systemic problems, including a perception that BC's criminal justice system inadequately addresses the needs of the Aboriginal community. Dozens of Aboriginal persons have died in police custody, many in extremely suspicious circumstances, yet no one has been charged or prosecuted in these cases.

62. UNNS perceives that the identity of the victim and/or the identities of those involved in causing Frank Paul's death may have unduly and inappropriately influenced the decision not to prosecute. This perception has grave implications for the public perception of the effectiveness of the criminal justice system, and for the prospects for true Aboriginal reconciliation within British Columbia.

63. While an evidentiary basis is necessary for an abuse of process argument, the Society would need access to the documents created during the decision-making process before it could confirm that the decision not to prosecute was properly motivated.

64. Inquiring into the Branch's role will not fetter or interfere with the exercise of prosecutorial discretion. Rather, it will review a past decision or decisions not to prosecute, with the object of ensuring that future prosecutorial decision-making and conduct is of a high standard. The Branch should welcome the opportunity to make a contribution to this important work.

The Paul Family and the First Nations Leadership Council

65. These participants adopted the submissions of Commission Counsel. They added that they, and the public, have many questions about who made decisions not to prosecute, and why. Until they are answered, a cloud hangs over the Branch. They considered that the Terms of Reference were a commitment to the Aboriginal people, and expressed surprise that what the Ministry appeared to offer with one hand is being taken away by the other.

BC Civil Liberties Association

66. The Association adopted the submissions of Commission Counsel. It added that the Commission needs to be able to look at what evidence each of the prosecutors looked at. The case authorities cited by the Ministry are distinguishable, because this Inquiry has no power to interfere with any decisions made, by or discretion exercised, by Crown prosecutors.

The Criminal Justice Branch's Involvement

The role of the Criminal Justice Branch

67. Although I have not yet heard any evidence respecting the Branch's response to Mr. Paul's death, it is my understanding that the Branch's only activity was in determining whether or not criminal charges would be laid.

A description of the charge assessment process generally

68. Section 4(3)(a) of the *Crown Counsel Act*, R.S.B.C.1996, c. 87, provides that each Crown Counsel is authorized to "examine all relevant information and documents and, following the examination, to approve for prosecution any offence or offences that he or she considers appropriate."

69. Pursuant to 2(e) of the Act, the Branch has developed policies and procedure. These include its *Crown Counsel Policy Manual* which, in a commendable exercise in transparency, is available on the Internet at http://www.ag.gov.bc.ca/public/criminal-justice/CJBPolicyManual.pdf.

70. I proceed on the assumption that this manual reflects the Branch's current policies. I recognize that the policies in place several years ago when the charge assessment decisions in the Frank Paul case were made may have been different. However, the issue before me in this application focuses on the role of Crown Counsel generally, rather than the specific policies in place during the Frank Paul assessments. If one or members of the Branch testify during Phase 2 as to their charge assessment activities in relation to the Frank Paul case, it will be important for me to be alerted to any differences between the current *Policy Manual* provisions, and the provisions in effect at those times.

71. One section of the *Policy Manual* (POL 1) deals with "Allegations Against Peace Officers." The policy states:

> In order to ensure that there is no perception of a conflict of interest and to maintain public confidence in the administration of criminal justice, the charge assessment decision on an allegation against a peace officer must be made by either Regional Crown Counsel or the Director, Legal Services.
>
> Regional Crown Counsel should make the charge assessment decision unless concerned that there could be an objectively reasonable perception of a conflict of interest or that the maintenance of public confidence in the administration of justice requires that the decision should be made at Headquarters. In either case, the matter should be referred to the Director, Legal Services for a charge assessment decision, pursuant to the procedure set out below.

72. From my review of the policy and procedure set out in POL 1, my understanding of this policy is as follows:

- This policy applies whenever it is alleged that a peace officer has committed a criminal offence, whether in the course of duty or not. (A different policy (SPE 1) applies in the case of "senior police officers." In such cases, the normal practice is to appoint a special prosecutor.)
- The police's Report to Crown Counsel is sent to the Administrative Crown Counsel in the location where the offence is alleged to have occurred.
- Administrative Crown Counsel forwards the Report to Regional Crown Counsel.
- Regional Crown Counsel should normally make the charge assessment decision, but should refer the matter to the Director, Legal Services for charge assessment if Regional Crown Counsel is concerned that:
  - There could be an objectively reasonable perception of a conflict of interest, or
  - The maintenance of public confidence in the administration of justice requires that the decision should be made at Headquarters.
- When the matter is referred to the Director, Legal Services:
  - it should be accompanied by a memorandum containing a brief recital of the relevant facts sufficient to carry out an assessment without reference to the police file. It should also include Regional

Crown Counsel's recommendation, unless the referral to the Director, Legal Services was due to a conflict of interest.

- If there is a difference between the Regional Crown Counsel's recommendation and the Director, Legal Services's decision, the matter should be referred to the Assistant Deputy Attorney General.

- Where there is an allegation that a peace officer's actions caused death, the Director, Legal Services will provide a copy of the material to the Assistant Deputy Attorney General.

73. The general "Charge Assessment Guidelines" policy (CHA 1) can be summarized as follows:

- The police's Report to Crown Counsel should provide an accurate and detailed statement of the available evidence. The basic requirements for every Report include:

  - a comprehensive description of the evidence supporting each element of the suggested charge(s),
  - when the evidence of a civilian witness is necessary to prove an essential element of the charge, a copy of that person's written statement,
  - necessary evidence check sheets,
  - copies of all documents required to prove the charge(s),
  - a detailed summary or written copy of the accused's statement(s), if any,
  - the accused's criminal record, if any, and
  - an indexed and organized report for complex cases.

- If the Report to Crown Counsel does not comply with these requirements, Crown Counsel may return it to the investigator with a request outlining the requirement to be met.

- In discharging the charge assessment responsibility, Crown Counsel must fairly, independently and objectively examine the available evidence in order to determine:

  - Whether there is a substantial likelihood of conviction; and, if so,
  - Whether a prosecution is required in the public interest.

- A substantial likelihood of conviction exists where Crown Counsel is satisfied there is a strong, solid case of substance to present to the Court.

In determining whether this standard is satisfied, Crown Counsel must determine:

- What material evidence is likely to be admissible,
- The weight likely to be given to the admissible evidence, and
- The likelihood that viable, not speculative, defences will succeed.

- Exceptional circumstances may require that a prosecution proceed, even though the usual evidentiary test is not satisfied. Such circumstances will most often arise in cases of high risk violent or dangerous offenders, or where public safety concerns are of paramount consideration. In these cases, the charging decision must be approved by Regional or Deputy Regional Crown Counsel, and the evidentiary test is whether Crown Counsel is satisfied that there is a reasonable prospect of conviction. This test is higher than a prima facie case. A weighing of admissible evidence and viable defences is not required. Crown Counsel should consider:

  - What material evidence is arguably admissible,
  - Whether that evidence is reasonably capable of belief, and
  - Whether that evidence is overborne by any incontrovertible defence.

- If the Crown is satisfied that there is a substantial likelihood of conviction, Crown Counsel must determine whether the public interest requires a prosecution by considering the particular circumstances of each case and the legitimate concerns of the local community. In making this assessment, Crown Counsel must consider a wide range of factors, including the following:

  - Public interest factors in favour of prosecution:
    - The allegations are of a serious nature,
    - Considerable harm was caused to a victim,
    - The victim was a vulnerable person,
    - The alleged offender was in a position of authority or trust,
    - The offence was motivated by bias, prejudice or hate based on race, national or ethnic origin, language, colour, religion, sex, age, mental or physical disability, or sexual orientation, and
    - There is a significant difference between the actual or mental ages of the alleged offender and the victim.
  - Public interest factors against prosecution:

- ♦ There is a likelihood of achieving the desired result without a prosecution by the Branch (e.g., alternative measures), and
- ♦ The offence was committed as a result of a genuine mistake or misunderstanding.

▪ Additional factors:

- ♦ Age, youth, intelligence, physical health, mental health or other personal circumstances of a witness or victim, and
- ♦ The need to maintain public confidence in the administration of justice.

o Crown Counsel has important obligations to make the charge assessment decision in a timely manner, to record the reasons for any charge assessment decision that differs from the police's recommendation in the Report to Crown Counsel and to communicate (where appropriate) with those affected (including the police) so that they understand the reasons for the decision.

o Finally, there are two situations in which Crown Counsel should discuss the charge assessment decision with Regional Crown Counsel or Regional Deputy Crown Counsel, before any decision is made:

▪ Where the allegation is that a person is responsible for a death, and

▪ For any serious allegation about which there has been, or is likely to be, significant public concern with respect to the administration of justice.

74. I will also make brief reference to one other section of the *Policy Manual*— "Charge Assessment Decision – Police Appeal" (CHA 1.1). It provides that:

o If the police disagree with a charge assessment decision, they should discuss their concerns with the Crown Counsel who made the decision,

o If the police are not satisfied with that discussion, they should contact Administrative Crown Counsel as the first step in appealing a charge assessment decision,

o If the matter is still not resolved, and if a chief constable, officer in charge of a detachment or more senior officer of the RCMP disagrees with a decision of Regional Crown Counsel, the Assistant Deputy Attorney General may be asked to conduct a further review of the charge assessment decision, and to respond to the police, and

- If, upon exhaustion of this appeal process, the police decide to swear an Information, it is anticipated that it would be sworn by, or on behalf of, a chief constable or the Assistant Commissioner of the RCMP, and that the Assistant Deputy Attorney General would be notified in advance of the Information being sworn.

75. I have set out at length these provisions from the *Crown Counsel Policy Manual* because they offer useful information about the types of information that a prosecutor should review during the charge assessment process, the procedure that should be followed and the legal standard that should be applied. This information will assist me greatly, as I turn now to a consideration of what material I need, in order to respond to paragraph (b) of the Terms of Reference, as it applies to the Criminal Justice Branch.

The types of concerns that I need to address respecting each prosecutor's assessment, in order to address the Criminal Justice Branch's "response"

76. I am satisfied that the Terms of Reference were drafted and approved by the Lieutenant Governor in Council because of significant public concern respecting the response of several public bodies and agencies to the death of Mr. Paul, including the response of the Branch.

77. Consequently, I am satisfied that, in order to fulfill my responsibilities in relation to paragraph (b) of the Terms of Reference, I need to be able to address the Branch's response which, according to the Ministry's written submission on this application, involved five separate charge assessment decisions, each of which was reviewed by the Assistant Deputy Attorney General.

78. On its face, I am satisfied that the word "response" in paragraph (b) includes both the procedures adopted, and the substantive decision made, in respect of each charge assessment decision. I will discuss later in this Ruling whether this interpretation of the word "response" needs to be reconsidered, in light of the Ministry's legal submissions about the independent exercise of prosecutorial discretion. Having regard to the general charge assessment process reflected in the *Crown Counsel Policy Manual*, I have concluded that in order to meet my responsibilities under paragraph (b), I need specific information relating to each prosecutor's involvement, including:

- The procedure followed:
    - What information did each prosecutor receive from the police, and did that information indicate that more information should be sought,
    - What charges, if any, did the police recommend, and against whom,
    - What additional information, if any, did each prosecutor request from the police, and why,
    - What criminal offences (and against whom) did each prosecutor consider, and why,
    - What legal research, if any, did each prosecutor undertake,
    - What communications, if any, did each prosecutor have with others (such as Crown Counsel or police officers) before making his or her decision,
    - What charging standard did each prosecutor apply,
    - If the two-step charging standard set out in the current *Policy Manual* was applied, was the decision not to charge based on the "substantial likelihood of conviction" test or the "public interest" test, and why,
    - Did the police appeal any of the decisions not to prosecute and, if so, what happened,
    - What information and documents, including any recommendation, did each prosecutor provide to the Assistant Deputy Attorney General, and
    - What other communication, if any, was there between each prosecutor and the Assistant Deputy Attorney General, before the latter made his decision?
- The timeliness of the decisions
    - When was each prosecutor assigned the charge assessment, and when was it completed, and
    - When did each prosecutor refer the charge assessment to the Assistant Deputy Attorney General, and when was his decision made?
- The objectivity of each prosecutor's assessment:
    - Was any prosecutor subjected to internal or external pressures or influences respecting the charge assessment decision and, if so,

what was the source and nature of those pressures or influences, and

- Did each prosecutor "fairly, independently and objectively examine the available evidence"?

- The substance of each prosecutor's decision

  - At the time that each prosecutor, and the Assistant Deputy Attorney General, made his or her decision not to approve charges, was he or she satisfied that he or she had considered all appropriate charges, all possible accused persons, all relevant information, all relevant legal analyses, and that the decision not to prosecute was made competently, and
  - Does he or she feel the same way today?

79. This list is, I acknowledge, extensive. However, this is the information I should have if I am to do justice to the task I have been assigned under paragraph (b) of the Terms of Reference. I reach that conclusion for the following reasons. First, I consider it to be the clear (and unambiguous) intent underlying the Terms of Reference. In my view, "response" should be interpreted broadly, to include all aspects of what the Branch did in response to the death of Mr. Paul.

80. Second, my responsibilities as Commissioner should be understood within the larger context of what happened to Mr. Paul, and the resulting questions that were raised respecting the integrity of the administration of criminal justice in British Columbia. I repeat an excerpt from the Information Bulletin dated March 9, 2007, that announced my appointment:

> Solicitor General John Les announced the inquiry on Feb. 22, 2007, in response to ongoing public concern and interest in the Frank Paul matter, and a need to ensure public confidence in the administration of justice.

81. The Ministry has proposed an alternative to the prosecutors who made charge assessment decisions in this case testifying at this Inquiry:

> 8. The Criminal Justice Branch is, nevertheless, concerned with public confidence in the criminal justice system and any perceptions that exist that the charge approval process was not carried out in a careful and professional manner. Pursuant to these interests, the Criminal Justice Branch has offered to provide the Commission with a statement of the broad reasons for not prosecuting this matter, outlining the facts underlying the decision not to pursue charges in this case, the process

followed, and the standard applied. This will allow the Inquiry to review all relevant policies and processes, without reviewing the individual discretion exercised and legal advice provided.

82. The Ministry proposes (para. 10) to do so by tendering "an appropriate senior Criminal Justice Branch official," who would make this statement in writing or by way of oral evidence on oath.

83. Would this alternative suffice? In my view it would not, for the following reasons:

- First-hand evidence is available and, when it is, the Commission should not be forced to rely on second-hand evidence,
- What the Ministry is offering to provide, through a senior Branch official, does not appear to be as in-depth as the types of information I enumerated earlier,
- It is not clear whether the Ministry would permit its senior Branch official to be subjected to cross-examination by Commission Counsel and other participants,
- Some of the matters that I have enumerated earlier could only be adequately explored with the specific prosecutors, not a third party, and
- Most importantly, I am not persuaded that the public concern that triggered this Commission of Inquiry could be properly addressed through the Crown's proposed alternative procedure. The fact that the Criminal Justice Branch was included among the public bodies enumerated in paragraph (b) of the Terms of Reference satisfies me that there is public concern respecting the Branch's response, and this concern relates to both the processes followed and the decisions made. That being so, the Branch is currently under a cloud, for its response to Mr. Paul's death. It is too early to tell whether or not that cloud is warranted. Only a full and public examination of the Branch's charge assessment process will resolve that issue. The Crown's proposed alternative asks me, and the public, to "trust us." In my view, my mandate will not be properly fulfilled by the procedure proposed by the Criminal Justice Branch. If there is suspicion in some quarters that the Branch's response to Mr. Paul's death was inadequate, my willingness to rely on second-hand evidence respecting that response, when first-hand evidence is available, would not extinguish that suspicion—it would likely inflame it. The purpose of a public inquiry into the death of an individual when there was police involvement is to assure the public of the integrity of our criminal justice system (or, if it is not performing with integrity, to recommend measures that will restore integrity). In this circumstance, I have concluded that I

> cannot fulfill my responsibilities relating to the Branch's response to the death of Mr. Paul, without hearing first-hand from the five prosecutors who made the charge assessment decisions, and from the Assistant Deputy Attorney General who reviewed those decisions.

84. I emphasize that I have reached this conclusion without prejudging the Crown's legal argument (that the independent exercise of prosecutorial discretion is immune from review by this Commission of Inquiry), which I will address later in this Ruling.

The Commission of Inquiry's Statutory Authority

85. Before addressing the Crown's argument directly, I will summarize those provisions of the *Public Inquiry Act* that I consider to be relevant to this application. I do so in order to provide an appropriate context within which to consider how they relate to the Ministry's position that prosecutorial discretion is immune from external review, whether the legislation has extinguished any such immunity, or whether there is an ambiguity in the legislation.

Power to inspect and copy records

86. Section 10 states that a commission may conduct an inspection of a public place, including copying any records found in that place. With the permission of the owner or occupier, the commission may do so in relation to a private place. If the owner of a private place withholds permission, a commission may apply to the court for a warrant (s. 23(c)).

Rights of participants

87. Section 13(2) and (3) state:

> (2) A participant
>
> (a) has the same immunities as a witness who appears before the court, and
>
> (b) is considered to have objected to answering any question that may
>
> (i) incriminate the participant in a criminal proceeding, or
>
> (ii) establish the participant's liability in a civil proceeding.

(3) Any answer provided by a participant before a commission must not be used or admitted in evidence against the participant in any trial or other proceedings, other than a prosecution for perjury in respect of the answer provided.

88. The Ministry submits that "immunity" in s. 13(2)(a) includes Crown immunity, and that this provision supports its position that the independent exercise of prosecutorial discretion is immune from review by a commission established under this Act. Commission Counsel submits that this provision refers to "use" immunity, which protects a witness from having his or her testimony before a public inquiry being used against the witness in other legal proceedings.

89. I am satisfied that the intent of s. 13(2)(a) is to focus on ordinary witnesses who routinely appear before a court. Whatever immunities apply to such witnesses in a court setting extend, by virtue of s. 13(2)(a), to participants who appear as witnesses before a Commission of Inquiry under this Act. I am satisfied that this provision was not intended to be a reference to the rule that precludes certain types of interference with the independent exercise of prosecutorial discretion.

90. Even if the Branch is correct that the issue before me on this motion is Crown "immunity," and that s. 13(2)(a) applies to the prosecutors who made charge assessment decisions in the Frank Paul matter, it does not follow that this provision exempts them from testifying. According to the Branch, the core area of prosecutorial discretion that is immune from review relates to the charge/no charge decision and the basis for a proper charge; I am precluded from second-guessing that judgement call. The Branch claims no protection over what transpires earlier in the charge assessment process, which includes much of the information and many of the documents that I require in order to address Term of Reference (b). If such information and documents are not protected, then it logically follows that the prosecutors who made the charge assessment decisions can be required to testify respecting those matters.

Summons to attend and give evidence

91. Section 22(1)(a) states that a hearing commission may serve a summons requiring a person to attend a meeting or hearing to give evidence on oath or affirmation. Under s. 23(a), a commission may apply to the court for an order directing a person to comply with such a summons.

92. Subsection (2) states that: "A person cannot be compelled to disclose to a hearing commission anything that, in any court, would be privileged under the law of evidence." I will address, later in this Ruling, the Ministry's argument that legal professional privilege applies to materials provided to the Assistant Deputy Attorney General by the five prosecutors who made charge assessment decisions in this case, and that this subsection protects the Branch from compelled disclosure.

Summons to produce information or a thing

93. Section 22(1)(b) states that a hearing commission may serve a summons requiring a person to produce for the commission, or a participant, information or a thing in the person's possession or control. Under s. 23(a), a commission may apply to the court for an order directing a person to comply with such a summons.

Crown documents

94. Section 29 of the Act is particularly important to this application. It states:

> (1) If the government discloses to a commission, either voluntarily or in response to a request or summons, any information over which the government asserts privilege or immunity, the privilege or immunity is not waived or defeated for any other purpose by the disclosure.
>
> (2) If a commission determines that it is necessary to disclose information over which the government asserts privilege or immunity, the privilege or immunity is not waived or defeated for any other purpose by the disclosure.

95. When such information is received by the Commission, two other provisions of the Act come into play. Section 15 deals with a commission's power to prohibit or limit attendance at a commission's meeting or hearing, or access to information provided to or held by the commission. It states in part:

> (1) A commission may, by order, prohibit or restrict a person or class of persons, or the public, from attending all or part of meeting or hearing, or from accessing all or part of any information provided to or held by the commission,
>
> (a) if the government asserts privilege or immunity over the information under section 29 [disclosure by Crown].

96. Section 26 deals with issues respecting freedom of information and protection of privacy. It states in part:

> (1) The *Freedom of Information and Protection of Privacy Act*, other than section 44(1)(b), (2), (2.1) and (3) [powers of commissioner in conducting investigations, audits or inquiries], does not apply to any of the following in respect of a hearing commission....
>
> (b) any information received by the commission to which section 15 [power to prohibit or limit attendance or access] or 29 [disclosure by Crown] of this Act applies....

97. On its face, s. 29 contemplates the government providing to a commission information over which it asserts privilege or immunity. Subsection (1) affirms that in the case of such disclosure, the privilege or immunity is not waived or defeated for any other purpose.

98. Subsection (2) goes further. It gives a commission the authority to disclose information over which the government asserts privilege or immunity, if the commission determines that disclosure is necessary. In the case of such disclosure, the privilege or immunity is not waived or defeated for any other purpose.

99. Section 15 then provides that if the government asserts privilege or immunity (under section 29) over information provided to or held by the commission, then the commission may impose restrictions on who may attend the hearing or access the information. I understand this to empower a commission to restrict access to such information; in other words, to minimize any damage to the government that may ensue from publication of this information.

100. Finally, s. 29 provides that the *Freedom of Information and Protection of Privacy Act* does not apply in relation to any information received by a commission over which the government asserts privilege or immunity. I understand this to preclude a person from obtaining disclosure of this information under that legislation—another safeguard to minimize unnecessary disclosure.

101. The Ministry's position is set out at para. 124:

> 124. ... Finally, section 29 of the Act makes it clear that the government may disclose certain information to a Commission and maintain its privileges and immunities, but clearly anticipates that there will be instances when the government does not, by virtue of the modifier "If."

102. As I understand the Ministry's position, the government (here the Branch) has a choice whether it will disclose to a commission information over which it asserts privilege or immunity. If the government refuses to make disclosure, that decision is final and the commission has no authority to order disclosure or to exercise its statutory powers of inspecting and copying records (s. 10) or summoning a person to attend and give evidence or produce information (s. 22). If it decides that it will disclose, then the privilege or immunity is not waived or defeated for any other purpose.

103. I do not accept the Ministry's argument, for the following reasons. First, I am not satisfied that "immunity" as used in these sections of the *Public Inquiry Act*, was intended to refer to the issue that is under consideration in this application. The focus of this application is prosecutorial discretion in deciding whether to initiate criminal proceedings. It is generally accepted that in doing so, prosecutors must act independently. Judicial authorities sometimes state that the independent exercise of prosecutorial discretion is "immune" from external review, such as through an application for judicial review or through a self-governing body's disciplinary proceedings. I interpret "immune" in this context as meaning that the prosecutor's decision is "exempt" or "protected" from such external reviews.

104. However, in my view this type of exemption from external review should not be equated with the Crown's historical immunity from tort liability or with concepts such as public interest immunity. I am satisfied that the provisions of the Act discussed above apply to those immunities, not to prosecutorial discretion.

105. If I am wrong, and the word "immunity" in these sections applies to prosecutorial discretion, there is another reason why I do not accept the Ministry's argument. According to the Ministry, the government can choose under s. 29 whether to assert immunity for the commission's purposes. However, at other times the Ministry states that "Crown immunity cannot be waived," absent bad faith (para. 89). If prosecutorial discretion is an example of Crown immunity and consequently cannot be waived, then the Ministry's interpretation of s. 29(1)

cannot be correct. On the other hand, if it does not constitute Crown immunity, then there appears to be nothing barring the Branch from waiving it in appropriate situations.

106. I am satisfied that section 29 of the Act (its clear meaning, and when read together with sections 15 and 26 and in the context of the overall legislative scheme) requires the government to disclose information over which it asserts privilege or immunity. The Act includes safeguards, to minimize any damage resulting from disclosure:

- Under s. 29(1), any immunity attaching to information that has been disclosed is not defeated for any other purpose,
- Under s. 15, a commission who holds information over which the government asserts immunity may:
  - restrict or prohibit attendance at a commission meeting or hearing where such information is disclosed, or
  - restrict or prohibit access to such information.
- Under s. 29(2):
  - a commission must not disclose such information unless the commission determines that it is necessary to do so, and
  - if the commission discloses such information, any immunity attaching to the information is not defeated for any other purpose.
- Under s. 26, a member of the public has no right of access to such information under the *Freedom of Information and Protection of Privacy Act*.

107. This conclusion, that the Act requires disclosure of information over which government asserts privilege and immunity, is consistent with the public policy underlying commissions of inquiry. Where, as here, public concern has been voiced about the conduct of important public bodies (including the police, the Ambulance Service, the Coroners Service, the Police Complaint Commissioner and the Criminal Justice Branch) and about public confidence in the administration of justice in British Columbia, a commission needs the tools and capacity to ascertain what happened. In my view the *Public Inquiry Act* reflects a decision by the Legislative Assembly to foster the work of commissions of

inquiry, and in so doing strike a balance between a requirement for disclosure and safeguards to minimize any damage resulting from disclosure.

This Inquiry's Practice and Procedure Directive

108. This Commission of Inquiry adopted a Practice and Procedure Directive applicable to the evidentiary hearings, under the authority granted by s. 9(1) of the Act. The Ministry has cited several provisions from that Directive that use the same language as the Act does, in support of its arguments. I do not consider that these provisions of the Directive add any further weight to the Ministry's argument, than does the wording of the Act itself. The Directive was drafted so as to be as complete a code of procedure as possible, and numerous provisions within the Directive track the language of the Act exactly. This was done so that readers could rely on the Directive as a complete description of the various practices and procedures of this Commission under the provisions of the Act.

Prosecutorial Discretion

The nature of prosecutorial discretion

109. In *Krieger v. Law Society of Alberta* (2002), 168 C.C.C. (3d) 97 (S.C.C.) the Court discussed the concept of prosecutorial discretion as follows:

> 43. "Prosecutorial discretion" is a term of art. It does not simply refer to any discretionary decision made by a Crown prosecutor. Prosecutorial discretion refers to the use of those powers that constitute the core of the Attorney General's office and which are protected from the influence of improper political and other vitiating factors by the principle of independence....
>
> 45. ... A decision of the Attorney General, or one of his or her agents, within the authority delegated to him or her by the sovereign is not subject to interference by other arms of government. An exercise of prosecutorial discretion will, therefore, be treated with deference by the courts and by other members of the executive, as well as statutory bodies like provincial law societies.

110. The Court then set out the five core elements of prosecutorial discretion:

(a) the discretion whether to bring the prosecution of a charge laid by police;

(b) the discretion to enter a stay of proceedings in either a private or public prosecution;

(c) the discretion to accept a guilty plea to a lesser charge;

(d) the discretion to withdraw from criminal proceedings altogether; and

(e) the discretion to take control of a private prosecution

111. The Court added that prosecutorial discretion applies to "ultimate decisions as to whether a prosecution should be brought, continued or ceased, and what the prosecution ought to be for." On the other hand, it does not apply to decisions that do not go to the nature and extent of the prosecution, such as trial tactics or conduct (para. 47).

The origins and historical development of prosecutorial discretion

112. In *Krieger*, *supra*, the Court traced the origin of prosecutorial discretion to the royal prerogative. The office of the Attorney General started in England as early as the thirteenth century as the King's Attorney, who exercised on the King's behalf the prerogative to bring and terminate prosecutions. Although there are great differences between the constitution of the Canadian and English offices of Attorney General, the power to manage prosecutions of individuals for criminal acts has changed little since these early times and between these countries (para. 24). The Court added:

> 30 It is a constitutional principle in this country that the Attorney General must act independently of partisan concerns when supervising prosecutorial decisions....
>
> 31 This side of the Attorney General's independence finds further form in the principle that courts will not interfere with his exercise of executive authority, as reflected in the prosecutorial decision-making process.

The purpose of prosecutorial discretion

113. I agree with the Ministry that the decision whether or not to initiate criminal proceedings is vital to the rights of individuals who may be accused of a criminal offence. For that reason, such a decision must be made independently, objectively and with an appreciation of all relevant facts. Failure to do so threatens the integrity of the criminal justice system.

114. Certain types of external interference or improper influence may cause a prosecutor to make a charging decision for other reasons, such as currying favour with a superior, or to minimize the risk of a reversal by a court or of disciplinary measures by a governing body. Our criminal justice system must protect prosecutors from such pressures and influences, to improve the likelihood that charging decisions will be made objectively and impartially in the public interest.

115. That being so, any external interference or pressure that jeopardizes the independent exercise of prosecutorial discretion should be proscribed.

The types of external review that are proscribed

116. The courts have prohibited certain types of external review. For example, in *Krieger*, *supra*, the Court declared that subjecting prosecutorial decisions to political interference could erode the integrity of our system of prosecution (para. 32). In British Columbia, legislation has been enacted to minimize the risk of political interference. The *Crown Counsel Act*, *supra*, authorizes prosecutors in the Criminal Justice Branch to approve for prosecution any offence that the prosecutor considers appropriate (s. 4(3)(a)), and discourages the Attorney General or Deputy Attorney General from giving a direction with respect to the approval or conduct of any specific prosecution, by requiring that the direction be given in writing and published in the Gazette (s. 5).

117. In *R. v. Power* (1994), 89 C.C.C. (3d) 1 (S.C.C.) (cited with approval in *Krieger*, *supra*, at para. 31), the court stated that: "it is manifest that, as a matter of principle and policy, courts should not interfere with prosecutorial discretion. This appears clearly to stem from the respect of separation of powers and the rule of law." The Court accepted that if a court reviews a prosecutor's exercise of discretion, the court becomes a supervising prosecutor.

118. *Krieger*, *supra*, is also authority for the proposition that a provincial law society has no authority to initiate disciplinary or competency proceedings against a lawyer for his or her exercise of prosecutorial discretion. In that case, the prosecutor had failed to make full disclosure to defence counsel in a criminal proceeding. The Court ruled that the Law Society did have authority to take action in that case, because "disclosure of relevant evidence is not, therefore, a matter of prosecutorial discretion, but, rather, is a prosecutorial duty" (para. 54).

The Court cited with approval *Hoem v. Law Society of British Columbia* (1985), 20 C.C.C. (3d) 239 (B.C.C.A.). In that case the B.C. Court of Appeal ruled that the relevant legislation must be construed as not giving to the Law Society jurisdiction to inquire into the conduct or competence of Crown Counsel in exercising the discretion to determine whether criminal charges should be instituted or proceeded with.

119. In civil proceedings, a court will not expose a prosecutor to liability in damages for initiating criminal proceedings against a person unless it is established that the prosecutor acted maliciously. In *Nelles v. Ontario*, [1989] 2 S.C.R. 170 (S.C.C.), the Court rejected absolute immunity. A prosecutor could be found liable upon proof of an improper purpose or motive, a motive that involves an abuse or perversion of the system of criminal justice for ends it was not designed to serve (para. 55).

120. However, the Ministry has not cited any cases in which a Canadian court has ruled that a Commission of Inquiry does not have the authority to inquire into the exercise of prosecutorial discretion.

Circumstances in which protection against review can be defeated

121. The Ministry submits that the exercise of prosecutorial discretion is immune from any form of external review, unless an evidentiary foundation has been laid for bad faith or improper motive. While I do not question the existence of a bad faith exception, the rule may not be as absolute as the Crown contends. For example:

- s. 5 of the *Crown Counsel Act*, which permits the Attorney General to give a direction with respect to the approval or conduct of any specific prosecution, suggests that in some instances "political" considerations can override a prosecutor's decision-making;
- s. 4(4) of the *Crown Counsel Act* and Policy CHA 1.1 of the *Crown Counsel Policy Manual* establish a procedure under which the police may appeal a prosecutor's determination not to approve a prosecution. This appears to constitute a voluntary waiver by the Crown of its independent exercise or prosecutorial discretion;
- The Legislature has the power to grant to a Law Society disciplinary power in relation to prosecutorial discretion: *Hoem*, *supra*, at p. 255, and

Krieger, supra, at para. 31. This appears to establish that a Legislative Assembly may, by enacting legislation, override or defeat a claim to immunity from external review in the case of prosecutorial discretion.

Does the doctrine apply in this case?

122. I accept without question that prosecutorial discretion must be exercised independently and that it must be protected from certain forms of external interference or pressure. However, I do not accept that the law precludes this Commission of Inquiry from inquiring into the Criminal Justice Branch's exercise of prosecutorial discretion in the Frank Paul case.

123. In reaching this conclusion, I distinguish between the type of independent review contemplated by the *Public Inquiry Act*, from the type of external interference that existed in the cases relied upon by the Ministry. My role as a Commissioner is to inquire into what happened, make findings of fact, make proposals for reform and report ultimately to the public. That is to be contrasted to the intervention or interference in the cases cited:

- Political interference – in *Krieger, supra*, the Court declared that subjecting prosecutorial decisions to political interference could erode the integrity of our system of prosecution. I interpret the Court's reference to "political interference" as applying to a politician ordering a prosecutor whether or not to prosecute, or bringing political pressure to bear (e.g., risk of dismissal, etc.) in order to persuade the prosecutor to do as the politician desires.

- Judicial intervention – in *Power, supra*, the Court stated that courts should not interfere with prosecutorial discretion. I interpret the Court's reference to "interference" as applying to situations such as the following:

    - A trial judge in a criminal proceeding reviewing whether the prosecutor's decision to prosecute was justified and, if it was not, to judicially stay the proceedings,

    - A judge on judicial review reviewing whether a prosecutor's decision to prosecute was justified and, if it was not, to prohibit further proceedings. See *R. v. Regan* (2002), 161 C.C.C. (3d) 97 (S.C.C.) for a discussion of judicial stays of proceedings, in the case of prosecutorial abuse of process, and

    - A judge in a civil action for damages brought by someone who had been prosecuted, reviewing whether the prosecution was justified and, if it was

not, to compensate the plaintiff. See *Nelles v. Ontario*, *supra*, for a discussion of malicious prosecution, in the case of bad faith.

- Disciplinary proceedings – in *Krieger*, *supra*, the Court ruled that a law society has no authority to initiate disciplinary proceedings against a lawyer for his or her exercise of prosecutorial discretion. I interpret the Court's reference to "disciplinary proceedings" as applying to proceedings in which the prosecutor might be subjected to sanctions such as a fine, suspension from practice or disbarment.

124. One can readily understand how any of these types of proceedings, which may result in the prosecutor's decision being overturned, or in the prosecutor being exposed to civil liability or regulatory sanctions, could undermine the independent exercise of discretion, and tempt a prosecutor to act in his or her own self-interest rather than in the public interest. In my view, that is the "mischief" at which the rule is aimed.

125. The Commission of Inquiry situation is, in my view, qualitatively different. A commissioner has no authority to reverse a prosecutor's decision, judicially stay criminal proceedings, hold a prosecutor liable civilly for damages, or impose disciplinary sanctions. A commissioner's role is to inquire into what happened, make findings of fact, recommend reforms where appropriate, and inform the public. None of those functions interferes with a prosecutor or exposes him or her to sanctions.

126. However, I attach one caveat. The *Public Inquiry Act* gives a commissioner the authority to make a finding of misconduct against a participant or make a report that alleges misconduct by a participant (see s. 11(2) and s. 28(6)). In *Canada (Attorney General) v. Canada (Commission of Inquiry on the Blood System)* (1997), 151 D.L.R. (4th) 1 (S.C.C.), Cory J. defined "misconduct" as "improper or unprofessional behaviour," or "bad management" (para. 40). Although a finding of misconduct is different from the types of sanctions referred to above, it is analogous, because it clearly may harm the participant's reputation. For that reason, in my view it would be inappropriate for a commissioner to make a finding of misconduct or make a report that alleges misconduct by a prosecutor, in his or her exercise of prosecutorial discretion.

If the doctrine does apply to commissions of inquiry generally, has it been defeated in this case?

127. If I am wrong, and the general rule is that the exercise of prosecutorial discretion is protected from review by a Commission of Inquiry, has the *Public Inquiry Act* defeated that protection? As stated earlier, *Hoem*, *supra* and *Power*, *supra* support the view that it has. In *Hoem*, the court assumed that it would be within the power of the legislature to grant to a law society disciplinary power in relation to prosecutorial discretion (p. 255). In *Power*, *L'Heureux-Dubé J.* cited with approval ([1994] 1 S.C.R. 601, at 621–23) an article in the *Criminal Law Quarterly* which stated: "prerogative powers are subject to the supremacy of Parliament, since they may be curtailed or abolished by statute" ("Controlling Prosecutorial Powers – Judicial Review, Abuse of Process and Section 7 of The Charter," by Donna C. Morgan, (1986-87), 29 *Crim. L.Q.* 15, at pp. 20–21).

128. As discussed earlier, I am satisfied that in British Columbia the legislature has defeated, for the purposes of a Commission of Inquiry, any claim of immunity relating to the exercise of prosecutorial discretion. In my view s. 29 of the *Public Inquiry Act*, entitled "Disclosure by Crown," is clear and unambiguous, in requiring the Crown to make disclosure of information, even though the Crown asserts privilege or immunity. The commission may even go so far as to disclose such information if the commission determines that it is necessary to do so. For the reasons given earlier, I do not accept the Ministry's argument that the word "If" at the beginning of s. 29(1) gives the Crown the option of choosing whether or not it will make disclosure.

If the doctrine has not been defeated in this case, what is its scope?

129. If I am wrong, and the exercise of prosecutorial discretion is protected from review by a Commission of Inquiry, and the *Public Inquiry Act* has not defeated that protection, it is important to articulate precisely the scope of this protection. As noted earlier, the Ministry stated its position that the core area of prosecutorial discretion that is immune from review by this Commission of Inquiry is "the charge/no charge decision" (January 18, 2008, p. 168) and "the basis for a proper charge" (p. 169); this Inquiry is precluded from "second-guessing that judgement call" (p. 169). Counsel also gave examples of the types of

information and documents that are "fair game to look at" (p. 169), including the following:

- Communications between the Crown and police about investigative steps that need to be taken,
- The Crown's involvement in the investigation,
- How thorough the investigation was,
- What are the facts that were assembled by the police and deposited with the Crown for their assessment,
- What the body of evidence was that the police ultimately assembled for the Crown's consideration,
- What directions the Crown gave the police, or what investigative steps the Crown told the police to take,
- What policies were in place, and whether the Crown followed those policies, and
- Why an independent prosecutor was not appointed.

130. If the Ministry accepts that the types of information and documents referred to above are subject to review, then it logically follows that the prosecutors who made the charge assessments can be required to testify about those matters. Even if the prosecutors are not compellable to testify as to the charge/no charge decision and the basis for it, the Ministry has advanced no reason why they are not required to testify respecting matters arising earlier in the charge assessment process.

The Branch's duty to disclose the reasons for not prosecuting

131. There is one further limitation on the protection claimed by the Ministry. Section 15(4) of the *Freedom of Information and Protection of Privacy Act*, R.S.B.C. 1996, c. 165 states:

> (4) The head of a public body must not refuse, after a police investigation is completed, to disclose under this section the reasons for a decision not to prosecute

(a) to a person who knew of and was significantly interested in the investigation, including a victim or a relative or friend of a victim, or

(b) to any other member of the public, if the fact of the investigation was made public.

132. In its *Crown Counsel Policy Manual*, the Branch acknowledges its obligations under this provision: see "Disclosure of Information to Parties other than the Accused," DIS 1.1, pages 3 and 4. The offer by counsel for the Branch to provide a statement in writing generally outlining the reasons for not proceeding with a prosecution in the Frank Paul matter is no more than this legislation and the Branch's own policy require.

Judicial independence

133. The Ministry also submits that the exercise of prosecutorial discretion is a quasi-judicial function, and that subjecting such decisions to political interference or judicial supervision could erode the integrity of our system of prosecution: *Krieger*, *supra*. In *MacKeigan v. Hickman*, *supra*, cited by the Ministry, Donald Marshall was convicted of murder. The federal Minister of Justice ordered a reference to the Nova Scotia Court of Appeal under s. 617(b) of the Criminal Code. The court quashed Marshall's conviction, but noted that Marshall had contributed to his conviction and that any miscarriage of justice was more apparent than real.

134. A provincially-appointed Commission of Inquiry was established to inquire into the murder, and into the charging and prosecution of Donald Marshall, and his subsequent conviction and sentencing. The commission issued Orders to Attend to the five Court of Appeal judges who had sat on the Reference (one of them had been Attorney General when Marshall was investigated for, charged with and convicted of murder). It sought information about what record was relied on by the Court in reaching its conclusions, why certain affidavit evidence had not been admitted, and what factors led the court to conclude that there had been a miscarriage of justice. The judges declined to attend, and applied to the Nova Scotia Supreme Court for a declaration that the Commission had no authority to compel their attendance by virtue of judicial immunity. That court granted the declaration, and that decision was upheld by the Appeal Division.

135. The Supreme Court of Canada ruled that the fundamental principle of judicial immunity protected the judges from being compelled to testify about the decision-making process or the reasons for the composition of the court in a particular case.

136. McLachlin J., as she then was, writing for herself and two other judges (a fourth justice, Lamer J., reached the same conclusion), distinguished between judicial impartiality (which refers to the mental state possessed by a judge) and judicial independence (which refers to the relationship between judges and others, particularly others in the executive branch of government). Judicial independence involves individual independence (as reflected in such matters as security of tenure and financial security), and institutional independence of the court (as reflected in its institutional or administrative relationships to the executive and legislative branches of government (para. 55, 56)).

137. Referring to the Court's earlier rulings in *Valente v. The Queen*, [1985] 2 S.C.R. 673 and *Beauregard v. Canada*, [1986] 2 S.C.R. 56, McLachlin J. stated that the principle of judicial independence is important in Canada's liberal democratic society because the courts are not charged solely with the adjudication of individual cases, but also play a role as protector of the Constitution and the fundamental values embodied in it, such as the rule of law, fundamental justice, equality and preservation of the democratic process. This dual role requires that the courts be completely separate in authority and function from all other branches of government (paras. 58, 59). She added:

> 66 The judge's right to refuse to answer to the executive or legislative branches of government or their appointees as to how and why the judge arrived at a particular judicial conclusion is essential to the personal independence of the judge.... The judge must not fear that after issuance of his or her decision, he or she may be called upon to justify it to another branch of government.... As stated by Dickson C.J. in *Beauregard v. Canada*, the judiciary, if it is to play the proper constitutional role, must be completely separate in authority and function from the other arms of government. It is implicit in that separation that a judge cannot be required by the executive or legislative branches of government to explain and account for his or her judgment. To entertain the demand that a judge testify before a civil body, an emanation of the legislature or executive, on how or why he or she made his or her decision would be to strike at the most sacrosanct core of judicial independence.

138. McLachlin J. then turned to the Commission's desire to question the Chief Justice about the assignment of the former Attorney General to the panel sitting on the Reference. In rejecting the Commission's claim, she stated in part:

> 71 ... To allow the executive a role in selecting what judges hear what cases would constitute an unacceptable interference with the independence of the judiciary. Inquiries after the fact must be similarly barred, in my view. A Chief Justice who knows that he or she may be examined and cross-examined by the executive or its emanation on why he or she assigned a particular judge to a particular case may feel, consciously or unconsciously, pressure to select someone pleasing to the executive. Even if the Chief Justice did not permit himself or herself to be influenced by such a prospect, the public perception that he or she might have been influenced could harm the esteem in which our system of justice is held. In short, the principle of judicial independence which underlies judicial impartiality and the proper functioning of the courts would be threatened by the possibility of public inquiries as to the reason for the assignment of particular judges to particular cases.

139. In my view, the Court's focus in *MacKeigan* was the three branches of government (the judicial, the executive and the legislative), and it ruled that in relation to the two critical judicial functions—judicial impartiality in adjudication and the judiciary's role as arbiter and protector of the Constitution—judges must be independent.

140. The independence of the judiciary from the other two branches of government does not arise in the Ministry's application. Prosecutors in the Criminal Justice Branch are clearly part of the executive branch of government, not the judicial. However, the Ministry submits that in making decisions about whether or not to prosecute, prosecutors act in a "judicial" or at least a "quasi-judicial" capacity, and thus the *MacKeigan* principle ought to be extended to them.

141. In my view, *MacKeigan* does not go that far, nor do the other authorities cited by the Ministry. For example, in *Nelles v. Ontario*, [1989] 2 S.C.R. 170, in which the Court ruled that prosecutors are not absolutely immune from liability in tort for malicious prosecution, McIntyre J. stated at para. 76: "The 'judicial' nature of the Attorney General's decision to prosecute does not in any way render him a 'court', that is, an adjudicative entity."

Professional Legal Privilege

Solicitor-client privilege

The Branch's position

142. The Branch submits that in the case of allegations against peace officers, the *Crown Counsel Policy Manual* contemplates that legal advice is intended to flow from Crown Counsel up through senior Branch members, including the Director, for the ultimate consideration of the Assistant Deputy Attorney General, who has the ultimate authority over charge approval. In these circumstances, the Branch argues, a solicitor-client relationship exists within the Branch. The Assistant Deputy Attorney General is the "client" and at least some of the charge assessment activities of subordinate members of the Branch constitute "legal advice" to the "client" which is thus privileged. In the absence of waiver by the Assistant Deputy Attorney General, those communications cannot be disclosed to this Inquiry.

A statement of the rule

143. The traditional rule of evidence respecting solicitor-client privilege was set out in *Cross on Evidence*, 5th ed., 1979, p. 282:

> In civil and criminal cases, confidential communications passing between a client and his legal adviser need not be given in evidence by the client and, without the client's consent, may not be given in evidence by the legal adviser in a judicial proceeding.

144. In *R. v. Solosky*, [1980] 1 S.C.R. 821 (S.C.C.) the court stated that:

> The concept of privileged communications between a solicitor and his client has long been recognized as fundamental to the due administration of justice. As Jackett C.J. aptly stated in *Re Director of Investigation and Research and Shell Canada Ltd.* [(1975), 22 C.C.C. (2d) 70, [1975] F.C. 184], at pp. 78–79:
>
> > ... the protection, civil and criminal, afforded to the individual by our law is dependent upon his having the aid and guidance of those skilled in the law untrammeled by any apprehension that the full and frank disclosure by him of all his facts and thoughts to his legal advisor might somehow become available to third persons so as to be used against him.

145. The court cited Jessel M.R. in *Anderson v. Bank of British Columbia* (1976), 2 Ch. 644, at p. 649 for the rationale for the rule, as follows:

> The object and meaning of the rule is this: that as, by reason of the complexity and difficulty of our law, litigation can only be properly conducted by professional men, it is absolutely necessary that a man, in order to prosecute his rights or to defend himself from an improper claim, should have resource to the assistance of professional lawyers, and it being so absolutely necessary, it is equally necessary, to use a vulgar phrase, that he should be able to make a clean breast of it to the gentleman whom he consults with a view to the prosecution of his claim, or the substantiating of his defence against the claim of others; that he should be able to place unrestricted and unbounded confidence in the professional agent, and that the communications he so makes to him should be kept secret, unless with his consent (for it is his privilege, and not the privilege of the confidential agent), that he should be enabled properly to conduct his litigation.

146. While solicitor-client privilege is usually understood in the context of an individual who seeks legal advice from a lawyer in private practice, privilege can also apply in the case of government lawyers providing legal advice to their employers (see *R. v. Brown [Disclosure]*, [1997] O.J. No. 6163 (Gen. Div.), at para. 9, and *Idziak v. Canada (Minister of Justice)* (1992), 77 C.C.C. (3d) 65 (S.C.C.)), and in the case of the police seeking professional legal advice from Crown lawyers in connection with criminal investigations (see *R. v. Shirose* (1999), 133 C.C.C. (3d) 257 (S.C.C.)).

147. In *Brown*, one of the many issues before the court was whether the Crown was required to disclose legal advice provided by salaried lawyers to the Attorney General about whether the Attorney General should sign a direct indictment. The court decided that solicitor-client privilege was potentially available in such circumstances. In doing so, the court quoted *Waterford v. Australia* (1987), 163 C.L.R. 54 (H.C.), at pp. 74–75:

> I should think that the public interest is truly served by according legal professional privilege to communications brought into existence by a government department for the purpose of seeking or giving legal advice as to the nature, extent and the manner in which the powers, functions and duties of government officers are required to be exercised or performed. If the repository of the power does not know the nature or extent of the power or if he does not appreciate the legal restraints on the

> manner in which he is required to exercise it, there is a significant risk that a purported exercise of the power will miscarry.

148. In *Idziak*, the issue before the court was an internal memorandum submitted to the Minister of Justice by his officials respecting an extradition.

149. In *Shirose*, the court affirmed that solicitor-client privilege attached to legal advice provided by a salaried lawyer in the Department of Justice to an RCMP officer respecting the legality of a proposed reverse sting operation. The court stated that whether or not solicitor-client privilege attaches depends on the nature of the relationship, the subject matter of the advice and the circumstances in which it is sought and rendered.

Is there a solicitor-client relationship in this case?

150. The Branch's Book of Authorities A includes three versions of the *Crown Counsel Policy Manual*'s policy POL 1 ("Allegations Against Peace Officers"), dated January 1, 1991, October 1, 1999, and November 18, 2005.

151. According to the January 1, 1991 version, the Report to Crown Counsel is to be sent to the Administrative Crown, who is required to review the file for completeness and then forward the file, with his or her comments, to Regional Crown. Regional Crown is required to review the file, and take the following action:

- If the file alleges that the actions of a police officer have caused the death of another person, the file is to be forwarded directly to the Assistant Deputy Attorney General, for review and decision, and a copy is to be sent to designated Senior Crown Counsel.
- In other cases, Regional Crown is to forward the file to designated Senior Crown Counsel, along with a memorandum reciting the facts and Regional Crown's recommendation. Senior Counsel then makes the charge assessment decision, which is conveyed back to Regional Crown Counsel.

152. A disagreement between Regional Crown's recommendation and Senior Counsel's decision is to be resolved by the Assistant Deputy Attorney General.

153. According to the October 1, 1999 version, the procedure is substantially the same, except that when it is alleged that the actions of a peace officer have caused the death of another person, the charge assessment decision is made by the Director of Legal Services, not the Assistant Deputy Attorney General.

154. According to the November 18, 2005 version, the charge assessment decision is normally made by Regional Crown Counsel, but is referred to the Director of Legal Services for the charge assessment decision in two circumstances:

- If Regional Crown Counsel is concerned that there could be an objectively reasonable perception of a conflict of interest, or
- The maintenance of public confidence in the administration of justice requires that the decision be made at Headquarters.

155. That process appears to apply even when it is alleged that the actions of a peace officer have caused the death of another person. However, in such cases the Director will provide a copy of the materials to the Assistant Deputy Attorney General.

156. The January 1, 1991 version was in effect when the first Frank Paul charge assessment was commenced, but the October 1, 1999 version had come into effect before the charging decision was made. The October 1, 1999 version was in effect when all subsequent charge assessments were conducted.

157. Under the 1999 version, the charge assessment decision, when it was alleged that the actions of a peace officer had caused the death of another person, was to be made by the Director of Legal Services. I infer from the policy that the Assistant Deputy Attorney General was authorized to review such a decision, and reverse it if warranted.

158. While I accept the Branch's submission that decisions in such cases worked their way up the chain of command, with senior Branch prosecutors making the charging decisions and the Assistant Deputy reserving the right to review a charging decision and reverse it, I do not accept that this procedure established a solicitor-client relationship, with the Assistant Deputy as the client, for several reasons. First, the 1999 policy clearly gave the Director the authority to make the

charge assessment decision, even though the Assistant Deputy had the right to review and reverse the Director's decision.

159. Second, while the Director and Assistant Deputy may have benefited from comments, memoranda and recommendations from their subordinates, I do not think that this converts the Assistant Deputy into a "client." A more fitting analogy is that the Assistant Deputy was in the position of a senior partner in a law firm, and looked to subordinate lawyers in the Branch for assistance before he or she exercised his independent professional judgement, as the senior prosecutor in the Branch, to decide whether charges should be approved.

160. Third, the charge assessment process is qualitatively different from the circumstances in *Shirose*, *Brown* and *Idziak*. In *Shirose*, the RCMP looked to a salaried lawyer in the Department of Justice for professional legal advice as to whether the proposed reverse sting operation was legal. Similarly, in *Brown* and *Idziak*, the Minister looked to salaried lawyers in the department for professional legal advice as to whether it was appropriate to sign a direct indictment or to order extradition. In concluding that privilege was potentially applicable in those circumstances, the court in *Brown* made reference to the underlying rationale for the rule, as stated in *Waterford v. Australia*: "If the repository of the power does not know the nature or extent of the power or if he does not appreciate the legal restraints on the manner in which he is required to exercise it, there is a significant risk that a purported exercise of the power will miscarry." In other words, the Minister was dependent on legal advice, in order to know how to exercise the power.

161. In the charge assessment process, the situation is qualitatively different. Under the 1999 version, the initial charging decision was to be made by the Director of Legal Services, even when the actions of the peace officer had caused death. Although the policy did not state explicitly, I infer that the Assistant Deputy Attorney General had the authority to review that decision, and to reverse it if he considered it appropriate to do so. In the case of such a review, the Assistant Deputy may have been provided with materials from subordinates within the Branch. However, I do not consider those materials to constitute "legal advice" that the Assistant Deputy required, in order to know how to exercise his power (i.e., whether or not to reverse the Director's decision). To the contrary, the

Assistant Deputy was the most senior prosecutor in the Branch with a full understanding of the charge assessment process, who would bring his or her own professional judgement to bear on whether the Director's decision should be reversed.

162. Consequently, I conclude that under the Branch's policy, the Assistant Deputy Attorney General was not a "client," and no solicitor-client relationship existed, with the result that no solicitor-client privilege attaches to the documents in question in this matter.

Waiver

163. If I am wrong, and a solicitor-client relationship did exist, then the question arises whether privilege has been waived. In *S. & K. Processors Ltd. v. Campbell Avenue Herring Producers*, [1983] B.C.J. No. 1499 (B.C.S.C.), McLachlin J. stated:

> Waiver of privilege is ordinarily established where it is shown that the possessor of the privilege (1) knows of the existence of the privilege, and (2) voluntarily evinces an intention to waive that privilege. However, waiver may also occur in the absence of an intention to waive, where fairness and consistency so require.

164. In my opinion, s. 29 of the *Public Inquiry Act* is a clear statement by the Legislative Assembly that a government claim to privilege should yield, for the limited purposes of a public inquiry. Section 29 states:

> (1) If the government discloses to a commission, either voluntarily or in response to a request or summons, any information over which the government asserts privilege or immunity, the privilege or immunity is not waived or defeated for any other purpose by the disclosure.
>
> (2) If a commission determines that it is necessary to disclose information over which the government asserts privilege or immunity, the privilege or immunity is not waived or defeated for any other purpose by the disclosure.

165. For the reasons stated earlier in this Ruling, I do not accept the Branch's argument that s. 29 lets the government choose whether or not it will waive privilege.

166. If I am wrong, and s. 29 does not waive a government's claim to privilege, I am satisfied that it is the Crown that holds the privilege, and that through the Terms of Reference approved by the Lieutenant Governor in Council in the Frank Paul matter, the Crown has waived solicitor-client privilege in relation to the Branch's response to Mr. Paul's death. As discussed earlier, the Branch's only "response" to his death was to decide whether criminal charges should be laid arising out of that death. By instructing me to make findings of fact respecting the Branch's response, the only reasonable conclusion to be drawn is that the Crown desires that I undertake a thorough examination of that response. I agree with the submissions of numerous participants, that it would be incongruous for the Crown to instruct me to inquire into the Branch's exercise of its charge assessment authority, but then prevent me from examining many aspects of that process.

Documents subject to solicitor-client privilege

167. If I had concluded that privilege has not been waived, then I would have needed to adopt a procedure for ascertaining which documents are privileged, such as the sealing procedure discussed in *R. v. Brown [Disclosure]*, *supra*.

Litigation privilege

168. In *Blank v. Canada*, [2006] S.C.J. No. 39 (S.C.C.), Fish J. stated for the majority:

> 34 The purpose of the litigation privilege, I repeat, is to create a "zone of privacy" in relation to pending or apprehended litigation. Once the litigation has ended, the privilege to which it gave rise has lost its specific and concrete purpose—and therefore its justification. But to borrow a phrase, the litigation is not over until it is over: It cannot be said to have "terminated," in any meaningful sense of that term, where litigants or related parties remain locked in what is essentially the same legal combat.
>
> 35 Except where such related litigation persists, there is no need and no reason to protect from discovery anything that would have been subject to compellable disclosure but for the pending or apprehended proceedings which provided its shield. Where the litigation has indeed ended, there is little room for concern lest opposing counsel or their clients argue their case "on wits borrowed from the adversary," to use the language of the U.S. Supreme Court in *Hickman*, at p. 516.

> 36 I therefore agree with the majority in the Federal Court of Appeal and others who share their view that the common law litigation privilege comes to an end, absent closely related proceedings, upon the termination of the litigation that gave rise to the privilege: *Lifford*; *Chrusz*; *Big Canoe*; *Boulianne v. Flynn*, [1970] 3 O.R. 84 (H.C.J.); *Wujda v. Smith* (1974), 49 D.L.R. (3d) 476 (Man. Q.B.); *Meaney v. Busby* (1977), 15 O.R. (2d) 71 (H.C.J.*); Canada Southern Petroleum Ltd. v. Amoco Canada Petroleum Co.* (1995), 176 A.R. 134 (Q.B.). See also Sopinka, Lederman and Bryant; Paciocco and Stuesser.

169. In *Blank*, the issue of litigation privilege arose during a civil claim against the Minister of Justice for damages resulting from the Ministry's prosecution of the plaintiff for regulatory offences. The Court ruled that the privilege had expired because the file to which the plaintiff sought access related to penal proceedings that had been terminated. In deciding that the civil claim did not constitute "closely related proceedings," Fish J. stated in part at para. 43:

> The Minister's claim of privilege thus concerns documents that were prepared for the dominant purpose of a criminal prosecution relating to environmental matters and reporting requirements. The respondent's action, on the other hand, seeks civil redress for the manner in which the government conducted that prosecution. It springs from a different juridical source and is in that sense unrelated to the litigation of which the privilege claimed was born.

170. A similar distinction can be made in the Frank Paul case. While the documents in question here were prepared for the dominant purpose of a criminal prosecution, they are now sought for the purposes of a public inquiry, which springs from a different juridical source and is in that sense unrelated to the litigation of which the privilege claimed was born. Consequently, litigation privilege does not attach to these documents.

Conclusions

171. I am satisfied that the charge assessment process includes an element of prosecutorial discretion that must be exercised independently, in order to ensure that a charge/no charge decision is made in the public interest after a review of all relevant materials.

172. The courts recognize that some aspects of the charge assessment process should be protected from external interference. For the purposes of this motion, I adopt

the Branch's position that the core area of prosecutorial discretion that is protected from external interference relates to the charge/no charge decision and the basis for a proper charge.

173. The types of external interference that are precluded include such matters as disciplinary proceedings that may lead to sanctions being imposed against the prosecutor, or judicial proceedings that may result in the prosecutor's decision being criticized, quashed or reversed or that may expose the prosecutor to civil liability.

174. However, a Commission of Inquiry's examination of how the charge assessment process was conducted in a particular case is qualitatively different from these types of external interference, because it is limited to ascertaining what happened and, where appropriate, making recommendations for reform. It is not binding on, nor can it impose sanctions against, a prosecutor arising out of the exercise or prosecutorial discretion.

175. Consequently, I am satisfied that the principle precluding external interference with the exercise of prosecutorial discretion does not apply to a Commission of Inquiry, and that this Inquiry is authorized to inquire into the charge assessment processes followed in the Frank Paul case, including an examination of all relevant information and documents, and the questioning of the individuals who made charge assessments. That questioning may include an examination of their charge/no charge decisions (respecting which I understand there is no dispute), and the reasons for them.

176. While I consider it essential that the reasons for these decisions become part of the public record so that the public has a complete understanding of them, I do not propose to express any opinion about those decisions.

177. Had I concluded that this core area of prosecutorial discretion is immune from review by a Commission of Inquiry generally, then I am satisfied that such immunity from review does not apply to a commission appointed under the BC *Public Inquiry Act*, because s. 29 of that Act has clearly and unequivocally defeated any common law immunity. That being so, the "immunities" referred to in s. 13(2)(a) must be presumed to refer only to other immunities.

178. Further, had I concluded that this core area of prosecutorial discretion is immune from review by a Commission of Inquiry appointed under the BC *Public Inquiry Act*, then several results would follow. I would be precluded from inquiring into the charge/no charge decision and the basis for a proper charge. However, I would still be entitled to inquire into all aspects of the charge assessments prior to that final stage, and to require that the prosecutors who made charge assessment decisions testify respecting those matters.

179. I am satisfied that the relationship between the salaried prosecutors in the Branch, and the Assistant Deputy Attorney General, does not constitute a solicitor-client relationship, and that consequently no solicitor-client privilege attaches to communications between them.

180. However, if I had concluded that a solicitor-client relationship did exist, I am satisfied that privilege has been waived in this case, either because of s. 29 of the *Public Inquiry Act*, or because of the Terms of Reference that instruct me to inquire into the Branch's response to Mr. Paul's death.

181. Even if I had concluded that there was no waiver in this case, I am satisfied that the individuals who made charge assessment decisions in the Frank Paul matter can be required to testify as to what they did, what materials they reviewed, what decision they made and the reasons for it, and any other matters that do not constitute communications between themselves and the Assistant Deputy Attorney General respecting his exercise of prosecutorial discretion.

182. In closing, I wish to repeat what I said earlier. The fact that the Branch was included among the public bodies enumerated in Term of Reference (b) satisfies me that there is public concern respecting the Branch's response, and this concern relates to both the processes followed and the decisions made. That being so, the Branch is currently under a cloud, for its response to Mr. Paul's death. It is too early to tell whether or not that cloud is warranted. Only a full and public examination of the Branch's charge assessment will resolve that issue.

While I am satisfied that Term of Reference (b) instructs me to inquire into the charging decisions made and the reasons for them, I do not propose to express any opinion about those decisions.

_____
Commissioner W. Davies, Q.C.
Frank Paul Inquiry

Appendix J

RULING 5
Application to Call Further Witnesses
May 13, 2008

FRANK PAUL INQUIRY
WILLIAM H. DAVIES, Q.C., COMMISSIONER
APPOINTED UNDER THE PUBLIC INQUIRY ACT,
S.B.C. 2007, C. 9

Nature Of The Application

1. This application is brought by the United Native Nations Society (Applicant), one of the participants in this Inquiry, for an order that three additional witnesses be called during the evidentiary hearings—Sgt. Boyd, Insp. Rothwell (both of the Vancouver Police Department (VPD)), and a representative of the VPD information technology (IT) section.

Legal Framework

2. This hearing and study Commission of Inquiry is governed by the *Public Inquiry Act*, S.B.C. 2007, c. 9. Section 21(1) of the Act authorizes a hearing inquiry to hold oral hearings and to receive evidence under oath or affirmation, and s. 22(1) authorizes a hearing inquiry to serve a summons requiring a person to attend a hearing and give evidence, and to produce information in that person's possession or control.

3. Section 9(1) grants the authority to make directives respecting practice and procedure. Pursuant to that power, this Inquiry published a Practice and Procedure Directive for Evidentiary Hearings (see http://www.frankpaulinquiry.ca/rules-of-procedure.php). Rule 21 states:

The following rules apply to witnesses:

a. Commission Counsel shall decide who shall be called as a witness at the evidentiary hearings,

b. subject to Rule 22, Commission Counsel shall call and examine witnesses on behalf of the Commission, and may adduce evidence by way of both leading and non-leading questions,

c. each witness called shall, before testifying, be sworn or affirm,

d. each witness who testifies may during his or her testimony be represented by counsel or, with the approval of the Commissioner, by an agent,

e. the Commissioner may, on application by a participant, permit a participant to cross-examine a witness to the extent of that participant's interest. If the participants are unable to agree on an order of cross-examination, the Commissioner will determine the order,

f. subject to Rule 22, counsel for a participant is entitled to examine that participant last, regardless of whether or not counsel is also representing another participant,

g. after Commission Counsel has called all witnesses on behalf of the Commission, a participant may apply to the Commissioner for permission to call a witness and, if permission is granted, subrules (c) to (e) apply to each witness called by a participant, and

h. Commission Counsel has the right to re-examine any witness who has testified.

4. Under this Rule, Commission Counsel decides who will be called as witnesses. However, if Commission Counsel does not call a person who a participant wishes to be called, that participant may apply to the Commissioner for permission to call that person as a witness.

5. It is on this basis that the Applicant applies for permission to call Sgt. Boyd, to re-call Insp. Rothwell, and to call a representative of the IT section.

Submissions Of The Parties

6. On April 29, 2008, counsel for the Applicant filed a written submission in support of its application. On April 30, counsel for the Paul family and the First

Nations Leadership Council, by email, expressed support for the Applicant's position respecting Sgt. Boyd.

7. On May 5, 2008, counsel for VPD filed a written submission, taking the view that the application should be dismissed without an oral hearing. On the same date Commission Counsel filed a written submission asking that the application be dismissed.

8. On May 7, 2008, counsel for the Applicant filed written reply submissions. On May 9, 2008, I permitted an oral hearing on the application, at which counsel for the Applicant, counsel for VPD, Commission Counsel and counsel for the First Nations Leadership Council made submissions.

Sergeant Boyd

9. He was a sergeant in VPD's Major Crime/Homicide section when Mr. Paul died in December 1998. He retired in 2005, with the rank of Inspector. Although Det. Staunton was the lead investigator in the Frank Paul case, Sgt. Boyd (who was Det. Staunton's superior) did attend the scene and had some involvement in the criminal investigation that followed.

10. Commission Counsel interviewed Sgt. Boyd, determined that he had relevant evidence to give, and arranged for him to testify before the Inquiry on Monday, February 11, 2008. During the preceding weekend, Commission Counsel received word from VPD that Sgt. Boyd had a serious medical condition that precluded him from testifying. This medical condition arose just prior to the date of his intended testimony, and remains today. Commission Counsel has confirmed this medical condition with Sgt. Boyd and with counsel for VPD (Sgt. Boyd's employer), and has a letter from Sgt. Boyd's doctor confirming that he is unwell and unable to attend. Commission Counsel is satisfied that he is not medically fit to testify.

11. Sgt. Boyd has since sworn a 16-paragraph affidavit, in which he recounts his recollection of his involvement in the criminal investigation and his review of Det. Staunton's 1999 Sudden Death in Custody report. The affidavit has been marked for identification.

12. Counsel are agreed that the application respecting Sgt. Boyd is not to be decided on the basis of the relevance of his evidence, but on his unavailability. In the words of counsel for the Applicant: "If he is available, he should be called. If he is not available, the reason should be put on the record unless there is some compelling reason not to do so" (written submission, para. 6). In his written reply submissions, counsel also submitted that: "this Commission should not receive in evidence a lawyer-prepared Affidavit from Sgt. Boyd that addresses any facts in dispute, unless the evidence can be tested by cross-examination" (para. 11).

13. I agree that this application should be decided on the basis of whether or not Sgt. Boyd is available as a witness at this Inquiry. I am satisfied that Sgt. Boyd has a serious medical condition that renders him medically unfit to testify, and precludes his appearance as a witness. I am prepared to reach that conclusion based on Commission Counsel's assurances of the inquiries he has made, and of his receipt of a letter from Sgt. Boyd's doctor confirming that he is unwell and unable to attend. Out of respect for Sgt. Boyd's privacy, I will not require that the doctor's letter be filed as an exhibit.

14. In Sgt. Boyd's absence, I am satisfied that his affidavit is the best evidence available. I direct that it be entered as an exhibit proper in these proceedings. I appreciate counsel's concern about relying on evidence where the deponent has not been subjected to cross-examination. I will bear those concerns in mind in deciding how much weight to attach to this affidavit evidence.

Inspector Rothwell

15. In his written submission, counsel for the Applicant stated at para. 14:

> Insp. Rothwell supervised the Internal Investigation Section at the material time and is the witness in the best position to testify about the VPD's systemic approach to potential member misconduct. When he testified on the issue of next of kin notification, the Applicant's counsel deferred questions concerning the internal investigation into Frank Paul's death on the express understanding that Insp. Rothwell would return as a witness.

16. With respect to counsel's assertion that Insp. Rothwell supervised IIS at the material time, Insp. Rothwell testified (January 31, 2007, pp. 2–3) that he was transferred to IIS in June 2000 (when a sergeant) as an investigator. By that time

the Frank Paul criminal investigation had been completed, Cst. Instant had been disciplined, and Sgt. Sanderson would soon be disciplined. Insp. Rothwell testified that he played no role in any of those matters. He became acting head of IIS in March 2001, and was officially promoted to Insp. in charge of IIS in November 2001, where he remained until September 2003. His only role in the Frank Paul matter related to the next-of-kin notification investigation.

17. Counsel for the Applicant submits there was an express understanding that Insp. Rothwell would return as a witness. In order to address that issue, I have reviewed the relevant portions of the transcript, namely January 31, 2008 (pp. 57–61), and February 1, 2008 (pp. 61 and 62).

18. On January 31, during Insp. Rothwell's testimony, Commission Counsel advised me (p. 57) that he had received the previous day 20 volumes of documents from the office of the Police Complaint Commissioner. Since he had not yet had an opportunity to review the documents, he could not say whether there might be information in them relevant to the examination of Insp. Rothwell. He suggested that we continue to deal with Insp. Rothwell's evidence relating to the next-of-kin notification, "but that if anything else relating to the office of the Police Complaint Commission files which have just been produced arises that we'll recall Insp. Rothwell for that" (pp. 57–58). Following brief submissions by counsel, we proceeded on that basis.

19. On February 1, counsel for the Applicant sought clarification (p. 61) that Insp. Rothwell had been called at this time to testify respecting the *Police Act* complaint about improper or inadequate notification of next-of-kin, and that Insp. Rothwell was not in attendance at this time to discuss the other *Police Act* complaint about the circumstances in which Mr. Paul died. Counsel noted that the latter was the subject of an internal investigation, that many new documents had come up, and that Insp. Rothwell may be coming back to address the internal investigation of the death. He confirmed that he would not be questioning Insp. Rothwell on that matter, as it would be addressed later.

20. From my review I am not satisfied that there was, to adopt the terminology of counsel for the Applicant, an "express understanding that Insp. Rothwell would return as a witness." There was, at most, a qualified commitment on the part of Commission Counsel on January 31 that if, as a result of his review of the 20

volumes of documents that had just been produced by the Police Complaint Commissioner, further questioning of Insp. Rothwell was called for, then he would be re-called. This application is not, as I understand it, anchored in the OPCC's disclosure of 20 volumes of documents, but rather in Insp. Rothwell's role as the officer in charge of IIS. That being so, I am not satisfied that the Applicant can claim reliance on the understanding articulated by Commission Counsel on January 31.

21. Putting aside the issue of whether there was an understanding, this application raises, at a more general level, whether Insp. Rothwell should be re-called as a witness. To put it another way, does he have relevant evidence that the Inquiry should hear, in order to complete the evidentiary record? The two matters referred to by counsel for the Applicant are the internal investigation into Mr. Paul's death, and VPD's systemic approach to potential member misconduct.

22. With respect to the internal investigation, I am not satisfied that the Applicant has shown that Insp. Rothwell would have relevant evidence respecting the IIS's investigation into Mr. Paul's death that would justify re-calling him at this stage in the proceedings. In reaching that conclusion, I rely principally on the evidence that Insp. Rothwell was not involved in the criminal investigation or the disciplinary proceedings against Cst. Instant or Sgt. Sanderson, and did not become acting head of IIS until nine months after the IIS report was delivered to the Police Complaint Commissioner.

23. With respect to whether Insp. Rothwell should be re-called to testify about VPD's systemic approach to potential member misconduct, the focus of the Phase 1 and Phase 2 evidentiary hearings is on the events of December 5 and 6, 1998, and on how VPD and the other named public bodies responded to Mr. Paul's death. For the reasons stated, Insp. Rothwell has no relevant evidence respecting VPD's internal investigation into Mr. Paul's death. Having said that, VPD's current rules, policies and procedures are germane to Phase 4 of the Inquiry's proceedings, which is the more appropriate forum in which to examine systemic issues.

A Representative Of VPD's IT Section

24. In his written submission, counsel for the Applicant stated his understanding that all VPD emails for a period of time relevant to this inquiry have been purged or expunged and, if that is so, the Inquiry should receive testimony, tested by cross-examination, as to what exactly happened to any emails related to VPD's response to Mr. Paul's death.

25. In his written submission, counsel for VPD stated at para. 9: "Email was rarely used during the period of the initial investigation (1998–2000). It is unlikely that there were any significant emails that did not go into the paper files. For the witnesses whose involvement in the Frank Paul case extended into 2003 and later years (when archiving of VPD e-mailboxes commenced), the VPD uploaded the archived e-mailboxes of each of those witnesses and searched them for any relevant emails. All emails found were produced."

26. In his written submission, Associate Commission Counsel stated that he interviewed a computer technician with VPD's IT section, who advised him that their system did not archive emails prior to 2003. In his view, nothing would be gained by having this Inquiry hear from someone in the VPD IT section on this issue.

27. In his oral argument, counsel for the Applicant submitted that I should not accept, without sworn testimony tested by cross-examination, that VPD got rid of all emails prior to 2003.

28. There appears to be no dispute that VPD did not archive emails until 2003. I am satisfied that Associate Commission Counsel has thoroughly explored this issue, and I accept his conclusion that earlier emails are not available, except those that had been printed out and have been retrieved from paper files. I am satisfied that nothing would be gained by requiring a representative of VPD's IT section to testify on this issue.

Conclusion

29. Accordingly, the applications to call Sgt. Boyd, to re-call Insp. Rothwell and to call a representative of VPD's IT section are dismissed.

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Commissioner W. Davies, Q.C.
Frank Paul Inquiry

Appendix K

Participant Submissions

Summary and Overview

I wish to acknowledge and express my appreciation for the hard work of the participants who appeared before me. As indicated in Part 2 of my report, some 14 participants appeared by counsel.

Counsel for the participants participated in the cross-examination of witnesses called by Commission Counsel. I made no formal order respecting the order of cross-examinations or the length of cross-examinations. Counsel were able to cooperate and agree upon the order of cross-examination and worked hard to avoid duplication and repetition and focused on matters of concern to their particular clients. I appreciate that depending upon counsel to address and solve the inevitable daily issues of scheduling, sequencing and economy of effort placed a heavy burden on them. As a result however, I found my work proceeded much more smoothly and efficiently.

Institutional Participants

The Terms of Reference required me to inquire into and report on the response of the Vancouver Police Department and Police Board, the BC Ambulance Service and Emergency Health Services Commission, the BC Coroners Service, the Criminal Justice Branch, the Ministry of Attorney General and the four police complaint commissioners who held office during the consideration of the Paul matter.

Without exception these institutional participants made witnesses available to counsel for the Commission, cooperated in the scheduling of our work and were fair and forceful in representing the interests of their clients. I am particularly indebted to counsel for the Vancouver Police Department, who had the lion's share of the burden of arranging for the attendance of witnesses.

Finally, I want to acknowledge that each institutional participant looked carefully at the facts and acknowledged mistakes where they believed mistakes had been made and provided invaluable input with respect to what changes had been made since the death of Frank Paul and addressed potential ways of improvement. Although I have not in many cases accepted their view of the problem or appropriate solutions, my thinking has been assisted greatly by the participation of these expert and hardworking professionals.

Public Interest Participants

It was vital to the full airing of the issues that arose from the facts that participants who represented the interests of the Paul Family, the First Nations community, and the general public were able to obtain the resources to participate fully in the work of the commission. The Paul Family were able to participate throughout by counsel and their participation was gracious and measured. The First Nations Leadership Council and the United Native Nations Society both dedicated themselves to exploring the ways in which the facts surrounding Frank Paul's life and death needed to be understood from an Aboriginal perspective. Aboriginal Legal Services of Toronto participated throughout and were disciplined and thorough in helping me assess particularly the ways in which the institutional methods of dealing with Aboriginal persons failed to account for their distinctive needs. Finally, the BC Civil Liberties Association brought their customary passion to preserving our civil liberties and enhancing our civil society to bear on the evidence and policy issues.

In this appendix, I summarize the submissions made by the various participants both on the facts and on policy. I hope in doing so, the reader will be assisted in understanding who argued for what and why. I have also received and reviewed helpful submissions from members of the public, which are in the records of the commission but not summarized in this appendix.

1. Submissions of the Vancouver Police Department and Police Board

The VPD welcomed this inquiry and the opportunity for recommendations that will improve aspects of the policing and public-health systems. The VPD submitted that the evidence has shown that the system of using police jails to house intoxicated persons deemed to be violent, is not the best way to address the social and public-health challenges that chronic alcoholics present. Nevertheless,

it noted the Jail was functional, and lodged Mr. Paul in a warm, dry environment on hundreds of occasions before his death.

In response to the significant media criticism arising from the Paul matter, the VPD submitted that the most important reality emerging from the evidence is the complete absence of racism, malice or bad faith on the part of police officers, and the complete absence of evidence of an orchestrated "cover-up" of Mr. Paul's death. The VPD submitted that Mr. Paul's death was the result of errors in judgement by two police officers.

The VPD addressed in great detail the evidence surrounding Mr. Paul's life and death, and the department's response to his death. Mr. Paul interacted with the VPD on an almost daily basis in the mid-1990s. Many officers assisted him and had good interactions with him, but equally, his dealings with police could be strained.

The VPD acknowledged that Frank Paul would likely have lived if Sgt. Sanderson had not turned him away from the Jail that final evening. His was a serious error in judgement, but was not motivated by bad faith. Cst. Instant, too, made a serious error in judgement in deciding to leave Mr. Paul in the alleyway. Their conduct must remain the focus of the examination of the events of December 5, 1998.

The VPD addressed specific points where it had come under criticism for other officers' conduct that day and night, and defended the decision to let Mr. Paul crawl his way into Jail in the morning; the decision to take Mr. Paul to the Jail in the evening rather than calling an ambulance; the decision not to send Mr. Paul to the Detox Centre; and the practice of dragging him on the floor of the Jail.

Regarding the VPD's public response, the department pointed out that Mr. Paul's death was mentioned in media briefings immediately following his death. The VPD submitted that this proves the complete lack of intent to cover up his death. The VPD's Major Crimes Section investigation was not perfect, and Det. Staunton himself acknowledged deficiencies. The VPD cautioned that his investigation is now being examined with the benefit of hindsight, and with a level of scrutiny commensurate with a much larger budget. A standard of perfection should not be employed. His investigation was reasonably competent. His report contains the

same basic facts as emerged in the public hearings of this inquiry. Although it does not spell out inconsistencies and analyze specific criminal offences, as it might have, the inconsistencies were clear from a review of the report. The investigative steps taken were based on what was known at the time, rather than what is known now with the benefit of hindsight.

The VPD observed that the disciplinary response began with the VPD Internal Investigations Section itself initiating the complaint. The process led to an articulation of the nature of the two officers' errors, and the imposition of punishment on them. Once the range of available sanctions is understood, reasonable people can reach different conclusions. Sgt. Boutin's disciplinary report contains an appropriate analysis of the officers' conduct, and is supported by the evidence led at this public inquiry.

It appears that Frank Paul's family was not initially given accurate information about how he died. It has not been established, however, that the VPD provided inaccurate information. It was acknowledged that both the VPD and Coroners Service should keep better records as to how next of kin are contacted.

The PCC's final conclusions were not commented on by the VPD, but the manner in which the PCC dealt with the Paul file had the unfortunate and unnecessary effect of portraying the VPD in a very inaccurate light, including alleged facts in PCC Ryneveld's call for a public inquiry that were inaccurate and embellished.

The VPD did not take a position on the sufficiency of the civilian oversight mechanisms in the *Police Act*. However, it noted that given the minimal input the OPCC had in the VPD's internal investigation in the Frank Paul case, this case is not necessarily indicative of the manner in which the civilian oversight mechanisms in the *Police Act* were intended to function.

The VPD submitted that I should recommend a change in the manner in which persons who suffer from acute intoxication and chronic alcoholism are dealt with in Vancouver. The drunk tank was submitted to be a relic from a time when chronic alcoholism was seen as a moral issue. The practice of arresting people intoxicated in public, and housing them in the drunk tank, is not the VPD's preferred option. The department has maintained for a long time it should not be in this business. Extreme public intoxication, and chronic alcoholism, should be

dealt with as a public health issue. The VPD asks for a strong recommendation for a properly funded, separate sobering centre, which would accept all those persons currently arrested for being intoxicated in public and unable to care for themselves.

The "wet shelter" proposal should receive serious consideration for Vancouver. The VPD fully supported the involvement of the Aboriginal community in the treatment of chronic alcoholics who are Aboriginal.

2. Submissions on behalf of the Coroners Service

The Coroners Service submitted that it is not the organization it was in 1998–99. Back then, inquests were rare, and they did not have the purchase on the public imagination that they do today. Some thought that a coroner working without a jury was a better kind of response to a death, although today people want a jury to consider the facts and deliver its judgement.

The approach taken by the Coroners' office in the Paul case was properly determined by the responsible coroner. The chief coroner was to set policy and supervise, but the decision to proceed by Judgment of Inquiry was that made by the responsible coroner. It was submitted that from today's vantage point, one might disagree with her decision. But there was no indication of bad faith and no misconduct involved. She did her best to do the right thing. It was her call to make, and the legislation gives her the authority to make the decision. The legislation also permits the Solicitor General to effectively overrule the coroner if an inquest were felt necessary, but this did not happen.

The present-day Coroners Service *does* address police-related matters by way of inquests. That is what the public wants, and that is what now happens.

The Coroners Service acknowledged failing to contact the Paul family to apprise them of the fact and circumstances of Mr. Paul's death. As a result, the coroner was unable to take into account the views of the family in determining whether to proceed by way of inquest or by Judgment of Inquiry. The media attention in this case came afterward, and the decision about an inquest in the Paul case may have been different had the Paul family been notified properly.

The Judgment of Inquiry rendered in this case concluded that Mr. Paul was not left in a safe place. The Judgment's recommendations were not aimed at finding fault with the police—that is not its aim—but were directed at changing policies to prevent a recurrence of such a death. They were sound.

Were I to recommend an approach like the Ontario Special Investigations Unit, the Coroners Service agreed it could work very well with such a body.

It is important that this inquiry restore confidence in the public institutions involved in this commission. It may do so by identifying errors and being constructive. It should report on the changes made at the Coroners Service.

3. Submissions on behalf of former Police Complaint Commissioner Morrison

Mr. Morrison was, of course, BC's first Police Complaint Commissioner, from 1998 until resigning in 2002. On his behalf, it was submitted that his response was responsible and appropriate. He acted in consultation with his staff and relied on the facts known and their recommendations on what to do in many instances. He has never shifted blame and has always taken responsibility for the decisions he made.

It was argued before me that Dana Urban's criticism was hypocritical and uninformed. Mr. Urban never made a recommendation to hold a public hearing while he was at the OPCC, but was eventually very critical that none was held. Mr. Morrison now accepts that the initial recommendation (by Bill MacDonald), to hold a public hearing was sound, but that is with the benefit of hindsight. Mr. Morrison may be criticized for the decisions he made, but should not be the subject of any adverse findings by this commission. He exercised his judgement in good faith and acted in the public interest.

4. Submissions on behalf of former Police Complaint Commissioner Casson

Counsel for former Commissioner Casson outlined his role as an interim Acting PCC, which started in July 2002, about two months after Mr. Morrison's resignation, and continued until handing over to Mr. Ryneveld in February, 2003. In this seven-month period, Mr. Casson was concerned about the Paul file and he outlined the steps he took, including efforts to involve Ted Hughes to

prepare an independent report for the Paul family, which ultimately did not take place. Mr. Casson submitted that he had a difficult task in leading an office in a time of transition, and had to walk the line between making decisions and acknowledging his interim status. It was submitted with force that he handled this challenging task appropriately.

5. Submissions on behalf of Police Complaint Commissioner Ryneveld

In submissions for the PCC, counsel observed that it was Commissioner Ryneveld's efforts that kept alive the public demand for the creation of this public inquiry.

The OPCC submitted that the VPD should receive criticism for its approach to the OPCC request for identification of the previously unidentified Jail staff and police members seen on the Jail video. The approach taken by the VPD conveyed a false impression of best efforts and ongoing assistance. This serves as a stark example of the VPD's reluctance to accept the concept of full civilian oversight. In addition, the VPD was reckless in suggesting that the OPCC manufactured evidence to support its call for a public inquiry.

It was submitted that since it appeared from Det. Staunton's evidence that the inconsistencies in the evidence had really become apparent only during questioning before me, that the first person to examine the police officers' statements analytically was OPCC investigator Bill MacDonald.

6. Submissions on behalf of Sgt. Sanderson

Counsel for Sgt. Sanderson submitted that the easy thing to do would have been to simply admit Frank Paul to the drunk tank. It was the Jail staff who brought to his attention that Mr. Paul did not appear to be intoxicated. Sgt. Sanderson considered the facts himself, and agreed with this view. He concluded that there were no legal grounds to hold Mr. Paul. Sgt. Sanderson's counsel submitted that his sole intention in declining to admit Mr. Paul was to ensure he was not jailed without lawful cause.

It was submitted that Sgt. Sanderson had two reasons for believing Mr. Paul was not intoxicated when he was brought back to the Jail during the evening:

- First, he believed Mr. Paul could not obtain alcohol and get intoxicated in the short time since his earlier release from Jail.

- Second, he concluded Mr. Paul did not look markedly different than his appearance when relatively sober.

While I now have the benefit of the autopsy and other evidence, Sgt. Sanderson did not have such information at the time, and his conclusion was not reckless or unreasonable.

The evidence suggests that even when sober, Mr. Paul was passive and lethargic, rarely spoke, and would sit for extended periods. The likely medical explanation is Wernicke-Korsakoff Syndrome, as described in the evidence of pathologist Dr. John Butt. In addition, Dr. Butt's evidence spoke to the fact that a chronic alcoholic may not show obvious symptoms of impairment even after consuming a great deal of alcohol, because of his acquired tolerance. Sgt. Sanderson did not have the benefit of repeatedly viewing the video of the Jail, nor did he have the post-mortem report or toxicology results.

After he declined to admit Mr. Paul to the Jail, Sgt. Sanderson again chose not to do the easy thing: he did not have Mr. Paul released into the alleyway behind the police station. Instead he learned that Mr. Paul lived at Broadway and Maple, and directed the wagon driver to take him there. If Mr. Paul had been taken to a place out of the elements at Broadway and Maple, he would in all likelihood have slept through the night, just as he had done outdoors hundreds of times before. Evidence established that Mr. Paul habitually slept outside and would not stay put at shelters. He was acclimatized to outdoor living.

It was forcefully argued that Sgt. Sanderson's intentions were entirely commendable. He wished Mr. Paul to be returned to his home neighbourhood. His intentions were not carried out because the instructions he gave to the wagon driver were inadequate. Sgt. Sanderson has admitted his instructions were lacking and this is a significant acknowledgement of responsibility. Cst. Instant's decision to leave Mr. Paul in the alley behind the Detox Centre was a consequence of these instructions, although it was not an inevitable consequence. Cst. English, in fact, countermanded Sgt. Sanderson's direction and advised the wagon driver to leave Mr. Paul in the Detox Centre laneway.

7. Submissions on behalf of Cst. Instant

It was acknowledged by Cst. Instant in his evidence and submissions on his behalf that he made wrong choices, and that his decisions played a significant role in Mr. Paul's tragic death.

However, it was observed that the Downtown Eastside is a world of despair and desperation. Policing this area is difficult; officers face pervasive human misery. The training and background of a young officer leaves him ill-prepared for the reality of this environment. Cst. Instant's conduct must be understood within this context, and the fact that he was a very junior officer working within a paramilitary organization.

At the Jail, Cst. Instant was told in clear terms that his understanding—that Mr. Paul was severely intoxicated—was categorically wrong. Sgt. Sanderson said that Mr. Paul could walk and had a disability, and there was no dissent expressed on the fifth floor of the Jail. Cst. Instant repeated this same language in his radio dispatch call upon leaving the Jail.

He expects firm but fair conclusions, based on the evidence. Cst. Instant gave evidence that was generally consistent with, and supported by, other witnesses and documentary evidence, and in particular the audiotape transcripts from the Jail.

Cst. Instant's submission detailed the evidence as it related to his involvement, ultimately asking that his testimony be accepted as honest. It was submitted that there is no basis in the evidence to conclude that his conduct was in any way intentional, callous, malicious or symptomatic of a general indifference for Mr. Paul's life. Reasonable minds can differ as to the choices that might have been made that evening, but reasonable minds will accept that Cst. Instant proceeded with good faith.

8. Submissions on behalf of the Frank Paul family and First Nations Leadership Council

Counsel for the family and the FNLC stated that success had already been achieved in that the family and the public now have a record of how Frank Paul

died, and an accounting from all but one institution into their roles in Mr. Paul's death.

It was submitted that this is about Frank Paul, his disabilities, and the way in which he was treated by the dominant society. Whether his Aboriginal status is the governing reason why he died cannot be known on the evidence. What we do know is that it was his Aboriginal status that put him in a place of vulnerability.

The family and the FNLC asked some compelling questions in its closing submissions.

- How could Mr. Paul be released with no shelter, no money, and nowhere to go?
- In so rich a country, how could there be no intervention?

The Paul family graciously pointed out that there were flashes of humanity in the evidence, including the actions of a police officer who gave him a $2 coin. There were other examples of human compassion transcending the institutional conduct.

Counsel for the family and the FNLC submitted that Dr. Lohrasbe's evidence assists in understanding how such humanity can and should displace the institutional callousness apparent in the evidence.

It was submitted that Sgt. Sanderson was remorseless and morally disengaged. Although he may have fixed on a belief that Mr. Paul was not intoxicated, that was a preposterous conclusion.

Cst. Instant was confused, and one could empathize with his situation. Peggy Clement forgave him for his actions—speaking, she said, for her people and on Frank Paul's behalf—but she also expressed disbelief regarding Cst. Instant's claims of what he actually did. The institutional responses to Mr. Paul's death should be understood as deserving different treatment than individual reactions and conduct. Whereas individual people reacted in the moment, facing various pressures and some immediacy, the institutions had the benefit of an opportunity to reflect. These were decisions made from desks. The VPD set in motion a process that safeguarded the officers; it was not a real criminal investigation and

did not provide a basis for criminal charges. Was this just incompetence, or a systemic mechanism arising for cases where someone dies in police custody? The Coroners Service was quick to conclude that there would be no inquest, and its response failed Frank Paul and the people of BC. The OPCC, like the Coroners Service, made its decision too easily and too early: Mr. Morrison was not going to hold a public hearing. The Ambulance Service witnesses give us hope; their attendants exhibited professionalism and compassion. Other institutions should be renovated in their like.

9. Submissions on behalf of the Aboriginal Legal Services of Toronto

The ALST stated that it was important that Frank Paul was an Aboriginal man. The questions surrounding his death have festered for years for the public, and especially for the Aboriginal public. The record of the circumstances of his death would not be complete without identifying what role racism played in his death. Two themes emerge from the evidence. First, there are inadequate resources and services for the homeless population in Vancouver. Second, the province has failed to establish appropriate civilian oversight of the police. It has also failed to ensure that the Coroners Service and OPCC are accountable to the public, and serve the most marginalized members of society.

The ALST proposed four principal recommendations:

- First, intoxication should be decriminalized completely. Mr. Paul was a homeless man who suffered from alcoholism, and was repeatedly brought into police custody for being intoxicated. The effect of BC's laws and the police response was to continue to treat intoxication as a criminal issue. These provincial laws require clarification and they should be amended to restrict the police power to detain intoxicated people. I should also ask whether police are best suited to handling intoxicated individuals, and whether police jails and holding cells are the best place for them to be housed. The lack of guidance to officers on where a person such as Mr. Paul should go—to the Jail, to the Detox Centre, or elsewhere?—was a factor in his death. There should be a stand-alone sobering unit with greater resources. Police should have as little to do as possible with those found intoxicated and unable to care for themselves. There should be a "wet shelter" available to minimize the harm from alcohol consumption, as exemplified by the Annex Shelter in Toronto. The wet shelter should have an Aboriginal-specific component for Aboriginal residents.

- Second, there is a troubled history between Aboriginal people and the police. This is true in BC and nationally. The Commission should not omit the fact that Frank Paul was an Aboriginal person and that his identity may have contributed to how he was mistreated in December of 1998. The VPD should review its use of "caution" entries on the Canadian Police Information Centre (CPIC) computer database. Officers should be trained not just on cultural matters, but on the true history of First Nations peoples. It is necessary to build a new relationship between Aboriginal people and police forces.

- Third, BC's existing mechanisms for police oversight and accountability failed in the Paul case. Both the VPD investigative and disciplinary responses failed. The province should establish a civilian investigation agency similar to Ontario's Special Investigations Unit, but should be careful to ensure it is independent, properly resourced, and created with community involvement. The *Police Act* should be amended to grant the OPCC the ability to investigate complaints about the police. Serious matters should not be resolved by way of informal and confidential disciplinary processes.

- Fourth, the province must establish appropriate oversight mechanisms for the Office of the Chief Coroner. A Coroners Service Board should be created, which would be responsible for the oversight and accountability of the Coroners' office, and would create policy.

10. Submissions on behalf of the BC Civil Liberties Association

It was submitted that this commission has a unique opportunity to examine the responses of various institutional agencies to disenfranchised people such as Frank Paul, both in life and death. The BCCLA reviewed the evidence of the events surrounding Mr. Paul's death, and outlined a series of suggested conclusions. These included that Sgt. Sanderson was profoundly wrongheaded to conclude Mr. Paul could not have gotten drunk in the time since his release from Jail. Either Sgt. Sanderson was not truthful, or he committed a profoundly disturbing error in judgment. Sgt. Sanderson knew Frank Paul was homeless and testified he would be able to "bunk down" with someone at Broadway and Maple; in this evidence he was either untruthful or acutely naïve.

It was urged on me that Cst. Instant's account of the Cobalt Hotel conversation should be preferred to that of Cst. English. Cst. Instant's account of how he left Mr. Paul in the alley, however, was submitted to be highly suspect. The position

of his body in the alley in their submission justifies the inference that he was left in the same position he was found in, hours later.

The VPD's investigation of the death was woefully defective. It was then relied upon by various other bodies and agencies, and it then polluted each subsequent investigation and review. The disciplinary response led to lax punishments, given the severity of the conduct at issue, and did not involve any element of remediation for the officers. The VPD's next-of-kin notification investigation was likewise inadequate.

The Coroners Service failed to ensure that the facts of Mr. Paul's death were made a matter of public record. In this way it failed to uphold its mandate. An inquest should have been called.

The PCC had the last viable opportunity for a full public airing of the facts surrounding Mr. Paul's death. The case called out for a *Police Act* public hearing to have been held at an early stage. Mr. Morrison's handling of the case was informed by irrelevant considerations.

The BCCLA set out a series of recommendations, many for specific agencies, and two of a general nature. First, as set out in the ALST's presentation, public policy should move to the decriminalization of intoxication. Second, for cases involving death or serious injury, with police involvement, the police should not investigate themselves. Independent civilian oversight should be present at both the investigative and disciplinary stages.

11. Submissions on behalf of the United Native Nations Society

It was submitted that Frank Paul was one of society's most vulnerable members: a homeless, chronically alcoholic, Aboriginal man. He died prematurely, a victim not of circumstance or lifestyle, but of egregious police misconduct. The "system" then completely failed to respond to his death. To an Aboriginal community reeling from decades of abuse and injustice, the case became a symbol of the uneasy relationship between indigenous peoples and the rest of society. It raises the key question of why the death of an Aboriginal at the hands of police is treated with such indifference by the system. The UNNS wants Aboriginal people

to be treated with more dignity and respect than Frank Paul was shown in his life or death.

The UNNS submitted that members of the VPD failed Frank Paul, his family, and the community, and breached the public trust. Cst. Instant's decision to leave Mr. Paul where he did was inexplicable, indefensible and inhumane. The breach of trust extends to the VPD's investigators and to the department's concept of "neutral" investigations when the force's members were involved in causing someone's death. That "neutral" investigation report was ultimately relied on for police discipline and by the Coroners Service, as well as by Crown Counsel.

Frank Paul's death cannot be divorced from its context, which involves poverty and homelessness, chronic alcoholism, and systemic racism. The fact that Mr. Paul was Aboriginal called out for a heightened level of inquiry into the circumstances of his death. Yet his family was not told the true nature of his death, and the factor of race may have been a key factor in the resistance to a public airing of the circumstances of his death.

The UNNS asked the commission to make a few dozen specific findings on the facts relating to the events of December 5–6, 1998, and the response of agencies to Mr. Paul's death—in particular the inadequate response of the VPD, Coroners Service, and OPCC.

The UNNS proposed a number of recommendations:

- The VPD should emphasize ethical training including the principles advocated in Dr. Lohrasbe's report.
- Governments should address the issue of Aboriginal homelessness in Vancouver.
- There should be addiction treatment programs for Aboriginals, run by Aboriginals.
- A sheltered managed alcohol program for homeless chronic alcoholics should be initiated on a trial basis.
- The public agencies involved in the Paul case should actively seek applications from qualified First Nations people.

- Police should not investigate police where there is serious injury or death.
- An independent, civilian-supervised agency should do these investigations.
- Independent prosecutors should review the reports arising from every police-related death.
- The Coroners Service should conduct an independent investigation in all cases where an inquest is mandatory.
- Finally, coroner's inquests should be held within six months of the death.

Appendix L

The Most Vulnerable of the Vulnerable:

Aboriginal Chronic Alcoholics

in the Downtown East Side

REPORT FOR THE FRANK PAUL INQUIRY
SUBMITTED – AUGUST 5, 2008

PREPARED BY ARDITH WALKEM
PHONE: (604) 264-7557 FAX: (866) 282-5701
ARDITH_WALKEM@TELUS.NET

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The Most Vulnerable of the Vulnerable: Aboriginal Chronic Alcoholics in the Downtown East Side

Introduction

There are no Aboriginal organizations in the Downtown Eastside ("DTES") equipped to provide comprehensive services to chronic alcoholics in a similar position to Frank Paul. Despite the desire of many Aboriginal organizations to work together to develop, design and deliver culturally relevant services, the services that are currently provided are an inadequately funded patchwork which cannot adequately address the immediate and longer term needs of Aboriginal chronic alcoholics, many of whom are homeless or face concurrent mental health issues.

Aboriginal organizations and people report a number of barriers that impede Aboriginal chronic alcoholics from accessing existing services. (A list of the Aboriginal organizations we spoke with is contained in Appendix a—Aboriginal Voices. This report is based primarily on our conversations with Aboriginal organizations and people in the DTES.) There is no residential facility in the DTES. Before someone can enter a treatment program (and Aboriginal treatment centres are all far removed from the DTES) they must first be sober for a certain number of days and have attended a certain number of counseling sessions. These requirements are almost impossible for the Aboriginal chronic alcoholic to meet.[448]

Jurisdictional disputes between various levels of government have long plagued the organizations in the DTES that provide services to chronic alcoholics. For Aboriginal organizations this problem is exacerbated by the assumptions that exist within various governments or funding organizations that a different level of government is, or should be, providing funding for Aboriginal peoples. For example, the federal government has constitutional responsibility for "Indians" and "lands reserved for the Indians" under s.

[448] There is no specialized detox centre or residential treatment in Vancouver geared towards helping Aboriginal chronic alcoholics. The Vancouver Detox has a limited number of beds, does not offer services targeted to the specific needs of Aboriginal peoples and would not be accessed by chronic alcoholics who have no desire to stop drinking. The Vancouver Detox operates a Daytox aftercare program to assist people in maintaining their sobriety; however, this program requires that people have some form of home or shelter and would likely not be of any help to an Aboriginal chronic alcoholic who was homeless.

91(24) of the *Constitution Act*, 1867 but provides few services off-reserve and is reluctant to provide services to non-status Indians or Métis. The provincial and municipal governments may assume that the federal government is, or should be, providing funding. Independent funding organizations may likewise assume that Aboriginal organizations have more access to funding sources and so decline to provide any separate funding. Aboriginal organizations report that a significant amount of their time and resources is spent applying for funding. For Aboriginal organizations this process involves first educating funders about the particular needs of Aboriginal people to combat the assumption that funding is coming from somewhere else. There was a widely reported perception amongst Aboriginal organizations that they receive less funding than other organizations in the DTES.

> The existing service delivery system in urban areas is not working well for Aboriginal people. For the most part its cultural values are not those of Aboriginal people, and it does not respond appropriately to their cultural, spiritual and socio-economic needs. Fundamental reform should begin immediately. First, Aboriginal people should, wherever possible, receive services from Aboriginal institutions. These institutions must have adequate, stable funding. The expansion and creation of Aboriginal service institutions in major urban centres, whether as agencies of Aboriginal governments or as autonomous entities, is the most effective and systematic method of responding to the needs of urban Aboriginal people over the long-term and should be supported by municipal, provincial, territorial and federal governments. Second, Aboriginal people should be involved directly in the design, development and delivery of services provided by governments and mainstream agencies. Intensive and field-oriented cross-cultural training for non-Aboriginal service providers is essential.[449]

A lack of steady funding limits the ability of Aboriginal organizations to address the needs of Aboriginal peoples with chronic and severe addictions in the DTES. Funding is concentrated primarily with non-Aboriginal organizations. General service organizations such as DEYAS, Carnegie, DERA, Downtown Eastside Women's Centre,[450] ATIRA, Union

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[449] Royal Commission on Aboriginal Peoples, *Perspectives and Realities*, Vol. 4, (Ottawa: Supply and Services, 1996) at 569 ["RCAP, *Perspectives and Realities*"].

[450] Although the Downtown Eastside Women's Centre ("Women's Centre") [302 Columbia Street] is not an Aboriginal organization it has a high number of Aboriginal clients. The Women's Centre provides a wide range of services and programs to all women and their children in the DTES, including drop-in, recreation, self-help, housing, employment, mental health, harm reduction, counseling, and advocacy and referral services. Services are not generally Aboriginal focused, although support and counseling to survivors of IRS *(footnote continued)*

Gospel Mission, the Salvation Army and Saint James Church provide services that Aboriginal people access, although some Aboriginal people may only access these services to a limited degree and some Aboriginal people may refuse to access these services entirely. These organizations may have an Aboriginal component if Aboriginal people have managed to become and stay involved. However, it is likely that Aboriginal people are under-represented, or not represented, on the staff or management of these organizations. Aboriginal organizations compete with the larger general service organizations (that provide services to Aboriginal and non-Aboriginal people) and often are not successful at getting funding.

Funding inequities are based largely on the rationale that Aboriginal people make up a small percentage of the overall Canadian population and that non-Aboriginal organizations also provide services and programs to Aboriginal people. In reality, Aboriginal people are overrepresented in the chronically addicted population in the DTES and many Aboriginal people reject mainstream (non-Aboriginal) services because of the discrimination they encounter there. Although Aboriginal organizations have attempted to raise the unfair, inequitable distribution of funding with government officials, their concerns have not been addressed.

The end result is that, although Aboriginal people make up a significant portion of the chronically addicted population in the DTES who often face additional mental health issues or homelessness, there are few services provided directly by Aboriginal people and organizations for Aboriginal peoples in the DTES. This situation was succinctly summarized by the Royal Commission on Aboriginal Peoples:

> It is obvious that the current delivery system is seriously deficient in meeting the needs of urban Aboriginal people. They are being served by a system that is essentially foreign to them. Clearly, it must change.[451]

Aboriginal organizations make efforts—both formal and informal—to work together by referring clients to one another and being aware of the programs and service that each provides. For example, the Vancouver Native Courtworkers host a networking potluck every two months that representatives of organizations servicing the DTES are invited to.

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abuse are provided. The Women's Centre operates an emergency shelter from 10:00 p.m. to 8:00 a.m. at 412 Cordova Street. The shelter is open to 50 homeless, at-risk, mentally ill and addicted women.

[451] RCAP, *Perspectives and Realities* at 555.

The potlucks provide an opportunity for organizations assisting Aboriginal people to identify partnerships, fill in gaps in existing services and work together to find long-term solutions for Aboriginal clients. The Metro Vancouver Urban Aboriginal Steering Committee ("MVUASC") also provides a forum for Aboriginal organizations to meet and identify how they can work together to fill gaps in existing services.[452]

There is a compelling need for the creation and sustained funding of Aboriginal community-based programming for Aboriginal chronic alcoholics in the DTES.

Aboriginal Organizations

Below we provide a general summary of the Aboriginal organizations working in the DTES who work with Aboriginal chronic alcoholics (including those with mental health and homelessness issues). We have concentrated on Aboriginal organizations that operate in the relative vicinity of the DTES core.

The location and delivery of different services or programs outside the DTES remains a very big issue. Some Aboriginal chronic alcoholics reported that they will not (or cannot) access any services outside of the immediate area of the DTES. Aboriginal organizations spoke of the growing numbers of Aboriginal chronic alcoholics who are located outside of the DTES in areas centred around the Commercial Drive and Grandview areas, as well as other parts of the city. There is a high rate of chronically addicted Aboriginal youth, for example, in the Commercial Drive area and they are more likely to seek out and access services there, and also more likely to migrate to different areas of the city including the West End.[453]

(a) Vancouver Aboriginal Wellness Program

2nd Floor, 255 East 12th Avenue
Vancouver, BC

[452] MVUASC arose out of the federal government's national five-year Urban Aboriginal Strategy initiative and the Greater Vancouver Urban Aboriginal Strategy (GVUAS). The MVUASC brings together representatives of the urban Aboriginal community to discuss the needs of urban Aboriginal people and make policy and planning recommendations to the federal, provincial and municipal governments.
[453] Many two-spirited (gay, lesbian, bi-sexual and transgendered) Aboriginal youth are found in the West End, and many of them suffer from chronic addictions.

The Aboriginal Wellness Program ("AWP"), an initiative of the Vancouver Coastal Health Aboriginal Health Services branch, was established to complement and increase access to existing mental health services, and provide a coordinated approach to the development and delivery of culturally appropriate services to Aboriginal people in Vancouver. AWP provides mental health and addictions counseling to Aboriginal people and their families. Mental health clients are referred to a consulting psychiatrist who can provide a diagnosis, prescribe medications and the recommended therapy. Two clinical supervisors (one mental health and one addiction) oversee the work of therapists, support workers, Aboriginal women's victim assistance workers and a cultural support worker. The main offices of the AWP are located outside of the DTES on East 12th Avenue. Geographically, many Aboriginal chronic alcoholics would be unable to access their regular services.

The AWP has eight outreach workers who operate a drop-in clinic three days a week in the DTES (at 524 Powell Street). Outreach workers meet with women, men, and youth at the drop-in in the mornings and set up appointments, either with a consulting psychiatrist or AWP team members the same afternoon whenever possible at the DTES location. The AWP often refers clients to Hey'-Way'-Noqu, also a VCH Aboriginal Health contracted service, for long-term follow up and aftercare. However, the AWP can only provide referrals and counseling, not the specialized level of services and ongoing support needed by homeless chronic alcoholics.

(b) Aboriginal Front Door Society

384 Main Street
Vancouver, BC

The Aboriginal Front Door offers a supportive space where Aboriginal people in Vancouver's Downtown Eastside can reconnect with traditional approaches to community and healing.

The AFD provides a daily coffee drop-in, weekly community meetings, arts and crafts, drumming circles, healing circles, and training for Elders. The AFD is a culturally relevant entry point towards drug and alcohol treatment for First Nations community members who live with addiction.

The Aboriginal Front Door Society (the "AFD") is located next door to the Vancouver Main Street Police Station, and provides a drop-in centre, drug and alcohol treatment

referrals, cultural programming, traditional healing and Elder support services to Aboriginal people in the DTES. The AFD is a community-based organization that provides services developed and delivered by and for the Aboriginal people of the DTES. The AFD holds weekly community meetings, including specifically for elders, men and women, and Indian Residential School survivors.

The AFD has a very restricted budget and only one full-time staff member. The AFD receives small amounts of funding from various sources, including Human Resources and Social Development Canada, the City of Vancouver, Aboriginal Community Career Services Society, the Canadian Heritage Fund, the Centre for Sustainability, the Vancouver Foundation, and individual donors. Vancouver Coastal Health provides funding towards the AFD's Elder's group. The Anglican Church provides some funds for the Indian Residential School Healing Circle. The AFD distributes food provided by the from the food bank at the Vancouver Aboriginal Friendship Centre once a week.

In many ways, the AFD is more of a safe place for Aboriginal street people than it is a service. The AFD provides peer counseling and supports to people with substance abuse, mental health, Indian Residential School and other issues. The AFD refers people to the different service providers, assists them filling out forms and applications, and advocates with social and medical services. In large measure, the clientele at the AFD are Frank Paul's peers who have serious substance abuse and mental health issues as well as being poor and homeless. Many AFD clients do not meet the stringent requirements and criteria in place at existing shelters and facilities. They live and sleep on the streets through the night and line up at the AFD for coffee in the morning, some sleep on the street in front of AFD through the night.

The AFD attracts a significant number of Aboriginal people because it is run and staffed by Aboriginal people. AFD programs are developed by the various steering committees of which clients are a major part. The only rule is that people have to respect this space and one another. Even the most disruptive, intoxicated person stops and shows respect when they come through the door and hear the drums or sit in the healing or talking circles. The Aboriginal cultural context provided by the AFD is very important in creating a safe and welcoming space in the DTES.

(c) Vancouver Native Health Society

449 East Hastings Street
Vancouver, BC

The VNHS is the only Aboriginal-run health clinic in Vancouver. It offers a variety of health and wellness services in the DTES open to both Aboriginal and non-Aboriginal patients, including a walk-in clinic; a dental clinic; HIV/AIDS program; an Early Childhood Development Program (operated off-site at a nearby housing project); evaluation and diagnosis of mental health issues, and the Sheway Program. Sheway provides specialized prenatal, parenting, life skills, health, housing and employment support programs, as well as drug and alcohol counseling to at-risk or currently addicted pregnant women or mothers with children under 18 months in the DTES. Most Sheway clients are Aboriginal. Sheway does not currently provide a residential program.[454]

VNHS clients are primarily low-income or homeless people in the DTES who present with a number of concurrent physical/mental and substance abuse issues. Aboriginal clients often manifest additional problems relating to the trauma they or members of their family experienced at Indian Residential Schools.

The experience at VNHS highlights the importance of Aboriginal staffing and atmosphere. Although the VNHS employs both Aboriginal and non-Aboriginal staff, Aboriginal cultural values are reflected at the core of its programs, services and operations. VNHS offers services to both Aboriginal and non-Aboriginal people in the DTES, but reports that many of their Aboriginal clients will not go to a non-Aboriginal-run facility and therefore would not otherwise receive the services they need.

Several years ago there was a proposal initiated by the Vancouver Police Department to convert the old jail cells into a sobering centre. VNHS received a Request For Proposal to operate this facility. VNHS declined, however, because the funding offered to support the operations was wholly inadequate. The (then) Vancouver/Richmond Health Authority had only identified $250,000/year towards its operation, from which the Health Authority required that the facility operate 24/7, 365 days a year with a full-time qualified nurse, and include food, security, and staffing and so forth. VNHS would support a similar proposal in future if there was sufficient ongoing funding, and a commitment that the facility is run according to Aboriginal cultural traditions and values.

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[454] Sheway receives funding from the Ministry of Children and Family Development, Vancouver Coastal Health, the YWCA Vancouver, with additional contributions from the Children's and Women's Hospital, Health Canada – Canadian Prenatal Nutrition Program, the University of BC Trek Volunteer Program, and the United Way – Success by Six program.

(d) Native Courtworker and Counseling Association of British Columbia

50 Powell Street
Vancouver, BC

The Native Courtworker and Counseling Association of British Columbia provides culturally appropriate services to Aboriginal people and communities consistent with their needs. Our service is accomplished through access to counseling and referral services to clients with substance abuse and detox support issues; advocacy service for Aboriginal family and youth; and to facilitate and enhance access to justice by assisting clients involved in the criminal justice system.[455]

The Vancouver Native Courtworker Alcohol and Drug Program (the "Courtworkers") was established in 1970 to provide assistance to Aboriginal people who come into contact with the criminal justice system. In 1972, the Courtworkers expanded to include a drug, alcohol and mental health counseling component based on the recognition that a large number of Aboriginal people involved in the criminal justice system suffer from concurrent substance abuse and mental health issues. Now, the Courtworkers also provide services to people with chronic addictions even where they are not involved in the justice system.

The Courtworkers offer one-on-one, non-residential drug and alcohol counseling, follow-up and aftercare, as well as referrals to detox centres and residential treatment centres. Clients do not have to be court-ordered to access alcohol and drug services.

The Courtworkers incorporate Aboriginal cultural values and teachings as a strong component of their services and operate on a philosophy that the chances of reaching people and helping them in the long term are increased if they have a sense of ownership, responsibility and control. Clients may have concurrent substance abuse and mental health issues, lack basic housing or education, have no employment history, or be involved with the justice system. Approximately 40 percent of Courtworkers clients are homeless. Client assessments take these factors into account in developing a client-centred plan involving a team of Courtworkers, counselors and any other support

[455] Native Courtworker and Counseling Association of BC website: www.nccabc.ca.

workers attached to the client. Client teams meet regularly for a case conference to review the clients' treatment or service plan.

The Courtworkers are actively developing a residential treatment facility for Aboriginal people suffering from chronic alcoholism and addictions in the DTES. The Courtworkers approached the owner of 40 Powell Street (next door to the Courtworkers offices at 50 Powell Street) and offered to develop a proposal to renovate and take over management of the building, if they could create 32 units of social housing which would be connected to the counseling, services and support team offered by the Courtworkers. The owner agreed to the proposal if the Courtworkers could access the funding needed to renovate the property by having it designated a heritage building. The heritage designation has since been granted and renovations are under way. The Courtworkers have met with the surrounding businesses and neighborhood to seek their support for this residential treatment facility. The Courtworkers attribute neighborhood support to the positive relationship the Courtworkers have been able to establish between their clients and the surrounding neighborhood.[456]

Within the new residential treatment facility, the Courtworkers are exploring the possibility of creating ten "flop" beds for the winter months which would be available to Aboriginal people even if they were intoxicated, and provide a safe place for them to stay for a short time. This proposed facility would operate according to a Harm Reduction model, similar to a sobering centre. The facility would meet the critical needs of Aboriginal homeless chronic alcoholics, but would only be able to meet a small portion of the existing need.

The project is wholly independently funded to avoid the inter-jurisdictional, management and financial restraints and disputes associated with government funding.[457] The Courtworkers have been approached by several outside agencies who have offered to provide some funding, or to contract for a certain number of the new beds for their own programs. The Courtworkers have been reluctant to accept any such involvement if the likelihood is such that genuine partnerships will not be created and

[456] Clients have a strong sense of ownership of the Courtworkers space and actively protect businesses in the immediate vicinity from break-ins, and the back alley is one of the cleanest in the DTES because clients clean the alley themselves.

[457] If clients were on government assistance, their housing payment would fund the accommodation and services provided.

the strings or bureaucratic requirements attached to funding would interfere with or impede the project's progress.

(e) United Native Nations (Vancouver Local)

678 East Hastings Street
Vancouver, BC

The United Native Nations Society ("UNN") is a non-profit organization that advocates on behalf of its off-reserve Status, non-Status, and Métis members (generally, urban Aboriginal people) on issues such as poverty, housing, employment, land claims, criminal justice, education, child welfare, and health. The UNN is a political organization, and does not deliver or provide emergency shelter or treatment services, but focuses its efforts primarily on policy and political advocacy, including equal access to government programs, funding and services for all Aboriginal people. The UNN, in partnership with PIVOT, has been very vocal about the continued vulnerability of Aboriginal people with chronic substance abuse, mental health and homelessness issues, and against the violence experienced by this population (including by the police), and assists clients with making and following through with complaints of police violence. Many of the street-involved chronic substance users that we talked to identified the UNN as representing their political concerns as urban Aboriginal people.

(f) Pacific Association of First Nations Women

678 East Hastings Street
Vancouver, BC

The Pacific Association of First Nations' Women ("PAFNW") provides a Community Health Liaison Program, an Aboriginal Elder's Support Program, and homecare services to Aboriginal people in Vancouver. It does not provide emergency shelter, alcohol, drug, or mental health treatment, but offers advocacy and referral services to help people access these services.

On a continuum of services, the PAFNW primarily provides services to Aboriginal people who need assistance accessing health care, counseling, housing or other services. PAFNW's ability to help homeless chronic alcoholics is limited to providing counseling support or referring them to other Aboriginal organizations.

(g) Aboriginal Homelessness Steering Committee

Housed at Luma Native Housing
25 West 6th Avenue
Vancouver, BC

The Aboriginal Homelessness Steering Committee (the "AHSC") works in association with the Regional Homelessness Steering Committee (the "RHSC"). Members of the AHSC are volunteers comprised of 20+ representatives of various Aboriginal service providers who review and make recommendations to the RHSC on proposed Aboriginal projects submitted for funding. The AHSC meets regularly to discuss Aboriginal homelessness issues, funding, and ongoing proposal development and does a lot of advocacy work in an attempt to address Aboriginal homelessness issues. The AHSC has no staff and relies on the time and dedication of these volunteers. The AHSC does have a community entity that administers contract dollars granted to Aboriginal housing projects based on AHSC's recommendations but it does not have access to funding for research and development of long-term strategic planning. With respect to Aboriginal chronic alcoholics, the AHSC advocates an Aboriginal Housing First approach.

(h) Hey'-Way'-Noqu' Healing Circle for Addictions Society

401 – 1638 East Broadway
Vancouver, BC

Hey'-Way'-Noqu' Healing Circle for Addictions Society ("Hey'Way'Noqu") is a non-profit organization funded by Vancouver Coastal Health to provide culturally appropriate non-residential programs, services and support to Aboriginal people and families seeking help for drug and alcohol addictions, sexual abuse and mental health issues. Hey'-Way'-Noqu' provides addictions assessment, counseling and treatment services, including referrals to Aboriginal residential treatment centres located outside of the Lower Mainland, such as Round Lake (near Vernon), as well as follow-up and aftercare. Hey'-Way'-Noqu' operates according to a cultural healing modality and Aboriginal healing practices and traditions are the cornerstone of the services it provides.

Hey'-Way'-Noqu' provides mental health liaison and support services to Aboriginal clients suffering from concurrent substance abuse and mental health issues. Support workers assist clients in the community to restructure their daily lives and establish healthy social supports and relationships. Liaison workers assist clients in accessing

mental health and other services, and develop client-centred approaches that foster healing, cultural awareness and community integration.

Hey'-Way'-Noqu' does not have outreach workers operating in the DTES. Clients are referred to the program by existing organizations or people who voluntarily seek out their services. In a continuum of services, Hey'-Way'-Noqu' clients have either not quite reached Frank Paul's condition or have already made active steps towards recovery. Hey'-Way'-Noqu' has a 24-hour sobriety requirement to access programs and services. It does not have the funding or trained personnel to provide an emergency or crisis-type facility to help chronic alcoholics with concurrent mental health and homelessness issues.

(i) Aboriginal Mother Centre Society ("AMCS")

2019 Dundas Street
Vancouver, BC

The AMCS provides family, addictions, mental health and one-on-one counseling, as well as housing, life skills, traditional parenting, education and employment support and referral services, to homeless and at-risk Aboriginal women. The AMCS does not currently provide residential services. In partnership with Lu'ma Native Housing and as part of the Urban Aboriginal Homelessness initiative, the AMCS is one of the four Aboriginal agencies approved for funding under the Off-Reserve Aboriginal Housing Trust to provide future housing for Aboriginal women in Vancouver.

(j) Circle of Eagles Lodge Society ("COELS")

1470 East Broadway
Vancouver, BC

COELS provides two community residential facilities that offer counseling, education, employment, life skills, and drug and alcohol counseling and support for Aboriginal people in Vancouver: (1) COELS is a transitional facility for Aboriginal men released from federal prisons; and (2) Anderson Lodge Healing Centre for Women provides a barrier-free emergency shelter and a second-stage residential recovery program to homeless Aboriginal women on the DTES, and to those conditionally released from federal prisons. In 2007 COELS, in partnership with Lu'ma Native Housing, was awarded one of the four Aboriginal housing projects funded under the Off-Reserve

Aboriginal Housing Trust to provide future housing to Aboriginal men, women, youth and people suffering with alcohol and drug addictions in Vancouver.

(k) Helping Spirit Lodge Society

3965 Dumfries Street
Vancouver, BC

Helping Spirit Lodge offers a number of residential and non-residential programs and service, to Aboriginal women and their children in the Lower Mainland:

- Spirit Lodge is a residential 33-bed transition house for battered and abused Aboriginal women and their children.

- Spirit Way offers a second stage, 18-month housing and healing program to abused and battered Aboriginal women and their children. Residents are provided with culturally appropriate healing programs, as well as a 20-week pre-employment, family violence intervention and prevention workshops, and IRS survival counseling.

- Reclaiming Our Spirit is a non-residential wellness program for Aboriginal women that provides individual and group counseling, an Aboriginal youth drop-in centre, traditional parenting and support circles, community resource liaison, assistance and referrals, as well as a homeless outreach support service.

- E.A.G.L.E.S. SPIRIT offers a family violence intervention and prevention program for Aboriginal people who have experienced family violence, and hosts Alcoholics Anonymous and Narcotics Anonymous meetings.

- Outreach provides follow-up support, advocacy, referrals and liaison services to Aboriginal women graduating from the various programs offered by Helping Spirit Lodge Society, including providing ongoing cultural support as well as legal, financial, and medical assistance.

Helping Spirit Lodge is currently raising money to establish the Bernie Whiteford Memorial Wellness Centre. The Centre would bring together the administration, programming and facilities currently offered by Helping Spirit Lodge Society to Aboriginal people in Vancouver in one centralized location.

(l) Vancouver Aboriginal Friendship Centre

1607 East Hastings Street
Vancouver, BC

The Vancouver Aboriginal Friendship Centre (the "Friendship Centre") provides an array of drop-in cultural, recreational, employment and social services as well as a meeting space for Aboriginal youth, adults, families, and elders. The Family Support Services Program provides support, workshops and advocacy services to Aboriginal parents and hosts an Aboriginal fathers support group. An Outreach Worker and an electronic information kiosk provide information referral services to members regarding various Aboriginal family programs and services available throughout the Lower Mainland.

The Friendship Centre provides space for a number of Aboriginal-run programs and services including an Aboriginal Elders society, an Aboriginal daycare, and it also provides space for UNYA's recreational programs and Aries Project which offers street-involved Aboriginal youth, age 13 to 18 years, with educational and life skills programs and support. Although the Friendship Centre does not provide treatment or housing for those with chronic alcoholism, it opens its doors to provide emergency cold/wet weather shelter, and has space available for people to take showers.

The role of the Friendship Centre in helping to maintain or re-establish cultural identity is an important function and they see themselves as providing a "home away from home" for Aboriginal people living in the city. Weekly powwow and West Coast family nights provide members of the Aboriginal community the opportunity to come together to socialize, and participate in traditional dancing and singing.

Many Aboriginal people who we spoke with in the DTES considered the Friendship Centre (near the corner of Commercial Drive and Hastings Street) geographically remote and too far away for them to access. However, for others such as Aboriginal youth or chronic alcoholics located around the Commercial Drive or Grandview areas, the Friendship Centre is central.

(m) Urban Native Youth Association ("UNYA")

1618 East Hastings Street
Vancouver, BC

The Urban Native Youth Association ("UNYA") offers several programs and services to assist Aboriginal youth. In addition to educational, recreational and other services that focus on prevention, UNYA has several crisis intervention programs.

- Aboriginal Safehouse is a one-week self-referral, residential program that provides shelter and services for street-involved Aboriginal youth, age 16 to 18 years old.

- Young Wolves Lodge is a self-referral five-bed residential program for Aboriginal women aged 17 to 24 years. The program assists young mothers in getting off the street, regaining custody of their children, and provides counseling, life skills and parenting education.

- Young Bears Lodge is a non-residential 16-week program offering life skills training, individual and group support, cultural awareness, and alcohol and drug counseling to Aboriginal youth aged 13 to 18. Youth must be referred by a drug and alcohol counselor.

Many of the Aboriginal youth UNYA assists are reluctant to access mainstream non-Aboriginal services out of fear that they may become apprehended by the provincial child welfare system and permanently disconnected from their family. Other than the residential programs UNYA provides, there are no Aboriginal-run facilities available for substance addicted or street-involved Aboriginal youth in Vancouver. Non-Aboriginal services are viewed by Aboriginal youth as culturally irrelevant.

In UNYA's experience the Aboriginal youth street population both on the Eastside and in the DTES is growing and getting younger. Children as young as 11 years old have tried, been exposed to, or are addicted to crystal meth, alcohol and other substances. There is an acute and growing need for emergency shelter, counseling and age and culturally appropriate services and facilities for chronically addicted Aboriginal street youth.

A cultural healing approach is a key component of the services provided by UNYA. Many of their activities and healing practices are focused on helping youth to maintain (or for those raised outside their culture, to build for the first time) Aboriginal cultural connections. For this reason, UNYA often makes trips with youth to reconnect them with

Aboriginal communities by attending powwows, sundances and other cultural activities.[458]

UNYA is currently trying to raise $46 million for the creation of a Native Youth Centre on the Eastside of Vancouver. The Centre would allow UNYA to consolidate and expand the programs and services it delivers to Aboriginal youth, including alcohol and drug prevention and intervention.

(n) The Western Aboriginal Harm Reduction Society ("WAHRS")

412 East Cordova Street
Vancouver, BC

WAHRS is an Aboriginal group associated with the Vancouver Area Network of Drug Users ("VANDU") in the DTES. Membership is comprised of Aboriginal injection drug users and chronic alcohol or solvent users (rubbing alcohol, Lysol, Listerine, etc.) Over half of VANDU's members are Aboriginal. Members meet weekly to provide peer support and exchange information about the dangers and long-term physical and mental health effects related to chronic alcohol and solvent abuse.

WAHRS advocates for the development of culturally appropriate harm reduction programs and services, including the development of an alcohol maintenance program to wean members off of alcohol or solvents, access to detox and treatment services, and the creation of a 24-hour, barrier-free Aboriginal drop-in centre in the DTES where members can take Aboriginal people they find incapacitated on the streets. VANDU's members prefer not to call the Saferide or the Ambulance Service because they fear that the VPD will eventually be called and the person may not get the help they need or will be harmed while in custody.

[458] For a detailed account of the importance of cultural reconnection on a group of youth who had been raised within the child welfare system, see: Lindsay Kines, "The Lesson of Kitkatla" *Victoria Times Colonist* (July 23, 2006).

Does It Matter That Frank Paul Was Aboriginal?

Shared Barriers

There are shared barriers that all chronic alcoholics in the DTES face. Timing, location and treatment-oriented programming can be very real barriers to reaching chronic alcoholics who will not get the help they need if they have to wait to be sober or come down off a drug, wait or travel several blocks for an appointment, or if the main objective once they get to a facility is to get them into treatment or detox. Chronic alcoholics, particularly those who experience homelessness or mental health issues, are a very disorganized and isolated population. It is very difficult for them to follow through with referrals to drug, alcohol and mental health programs and services. Chronic alcoholics may be unwilling (because of sobriety requirements or safety concerns) or unable (because their behavior is too disruptive or they have been blacklisted) to use existing services. The end result is that chronic alcoholics who are homeless have nowhere to go unless they are picked up by the police, accepted into detox, or taken to hospital emergency rooms.

For Aboriginal chronic alcoholics the barriers to accessing services are greater. Aboriginal organizations identified the fact that Aboriginal people are the most vulnerable of the vulnerable and often have personal histories of dislocation from their home cultures and communities or through the Indian Residential School ("IRS") or child welfare systems that make it both more likely that they will end up with chronic addictions in the DTES, and less likely that they will be able to seek help than their non-Aboriginal peers.

Aboriginal People Are Overrepresented In The DTES And Numbers Are Growing

Although not all Aboriginal people who are homeless are also chronic alcoholics or substance addicted, there is a significant correlation between chronic addictions and homelessness. The Greater Vancouver Homeless Count ("Homeless Count") provides some guidance as to the numbers of Aboriginal chronic alcoholics in the DTES. The Homelessness Count states that 32 percent of the overall homeless population in the Lower Mainland is Aboriginal. Nearly 20 percent of those interviewed in the homelessness survey did not answer whether they were Aboriginal or not. Therefore, the

32 percent figure is likely low and the more accurate figure would be approximately 40 percent.[459] Many Aboriginal people (particularly women) are part of the hidden or unseen homeless as they may be chronic "couch surfers" and stay in very limited or cramped accommodations with their families or friends.[460] The Homeless Count has serious implications to the allocation and distribution of funds targeted to meet the needs of the homeless population, which includes many Aboriginal chronic alcoholics.

Aboriginal youth are the fastest growing population in the country, and a growing number of these youth are chronically addicted.[461] Given the growing population of Aboriginal youth, the number of Aboriginal chronic alcoholics in the DTES can be expected to increase in the foreseeable future.[462] An early intervention strategy is needed

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[459] United Native Nations Society. *Aboriginal Homelessness in British Columbia*. (Vancouver: United Native Nations Society, 2001). The undercounting of Aboriginal people among the street population in the DTES was an issue highlighted by Aboriginal organizations consulted.

[460] Native Women's Association of Canada. *Aboriginal Women and Homelessness: An Issue Paper* (Ottawa: Native Women's Association of Canada, 2007).

[461] The startling statistics regarding Aboriginal youth are shown in the research prepared for the City of Vancouver, Social Planning Department ("Inventory of Aboriginal Services, Issues and Initiatives in Vancouver") available online at: http://vancouver.ca/commsvcs/socialplanning/initiatives/aboriginal/tools/ directory/PDF/Research.pdf, which includes the following statistics:

> Approximately 60% of the Aboriginal population is under the age of 25.
>
> Up to 40% of Vancouver street youth are Aboriginal (City of Vancouver, Dr. Penny Perry) [However, the McCreary Centre, see footnote 16 below, lists this figure at 57%.]
>
> Up to 60% of the prostituted adults and youth are Aboriginal (Adolescent Street Unit).
>
> Aboriginal youth are much more likely to go to jail than their peers.
>
> A recent study of Youth at Risk indicates that 67% of the youth are not attending school and that 55% of respondents are First Nations (Vancouver Police Department, 2002).
>
> "The Aboriginal population in Canada is growing faster, and is much younger, than the general Canadian population ... the median age for the Aboriginal population is 23.5, compared to that of the Canadian population which is 38. In 2001, over one third of Aboriginal youth were under the age of 14.... These demographic indicators suggest that the well-being of Aboriginal people in cities has a direct impact on the well-being of the cities themselves, most especially in western Canada where a substantial number of Aboriginal people reside." [*Urban Aboriginal Youth: An Action Plan for Change*. Standing Senate Committee on Aboriginal Peoples, October 2003].

[462] A study done by the McCreary Centre Society, ["Against the Odds: A profile of marginalized and street-involved youth in BC" (Vancouver: McCreary Centre Society, 2007)] reports that the situation of Aboriginal youth is growing more critical at a rapid rate. Key findings (at 9):

> Aboriginal youth were disproportionately represented among youth who were marginalized and street-involved, and the percentage had increased sharply since 2000 (from 36% to 57%).
>
> Forty percent of [all] the youth had spent time in government care and almost one in ten (9%) were in a foster or group home at the time of the survey.

(footnote continued)

for Aboriginal youth to prevent them from developing severe and chronic addictions and their progression when they first hit the streets. While early intervention is needed, a number of Aboriginal youth already experience severe and chronic addictions in the DTES and their needs are different.

The Most Vulnerable Of The Vulnerable

The vulnerability of Aboriginal people to addictions and the lack of an appropriate societal response was summarized by Dr. Gabor Maté:

> The devastation wreaked by addiction among our first nations peoples is a national scandal—or it would be, were it to strike virtually any other segment of our population. Our country is strangely indifferent to its depredations among this marginalized group. We seem content to accept the high death toll that afflicts our native citizens, the low life expectancy, the high incarceration rate and the grinding poverty that both gives rise to substance abuse and results from it. We seem to comfort ourselves with the belief that the endemic drug addiction and alcoholism are unfortunate realities for which we, as a society, bear no responsibility. From both scientific and historical perspectives, such a view is distorted and self-serving....
>
> Addicts are made, not born, and the most common precursors are early childhood privation, neglect and abuse. For several generations, Canada's native children have been far more likely to suffer grinding penury, abuse and childhood substance addictions than non-natives. [463]

Aboriginal people are disproportionately represented among the chronic alcoholic or addicted population in the DTES.[464] The overrepresentation of Aboriginal people is not proportionally reflected in programs and services provided by Aboriginal people for

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Marginalized and street-involved youth were three times more likely to be physically and sexually abused than youth the same age in school (AHS 2003).

More than one in three of the youth reported that they had been sexually exploited.

[463] Dr. Gabor Maté, "Our Strange Indifference to Aboriginal Addiction" (*The Globe and Mail*, February 5, 2008).

[464] The Centre for Applied Research in Mental Health and Addiction, Faculty of Health Sciences, Simon Fraser University. "Housing and Support for Adults with Severe Addictions and/or Mental Illness in British Columbia" Michelle Patterson, et al. ["CARMHA"]; and Colleen Anne Dell and Lara Lyons, "Harm Reduction Policies and Programs for persons of Aboriginal Descent" (June, 2007) (Canadian Centre on Substance Abuse: Harm Reduction for Special Populations in Canada) ["Dell and Lyons, CCSA"] at 6: While more Aboriginal people, overall, are abstinent from alcohol, the rates of chronic addictions is higher within the Aboriginal population compared to the general Canadian population.

Aboriginal people in the DTES and the importance of having Aboriginal programs is often overlooked by governments and funding agencies.

While none of the general services available to chronic alcoholics or addicts expressly exclude Aboriginal people—indeed, all report that they provide services to Aboriginal people—there is a significant population of Aboriginal people who underutilize or refuse to use general services.[465] In addition to the usual barriers and obstacles faced by chronic alcoholics, Aboriginal people face additional racism and discrimination. This racism is experienced even within those places and organizations meant to help or provide services, including some shelters and community centres. Aboriginal organizations reported that it is more likely for Aboriginal people to be perceived as dangerous or disruptive (reflecting negative stereotypes about Aboriginal people)[466] and so even more difficult for them to access these services.

Part of the chronically addicted Aboriginal population that is often overlooked are those addicted to solvents such as Listerine, Lysol, or Chinese cooking wine. There are a number of "Listerine Gangs" throughout the city comprised of people who cannot afford drugs or alcohol, or who view solvents as less of a problem than drugs. These Listerine Gangs operate as families and have their own rules and support systems. They work together to panhandle, collect bottles and so forth to raise money to support their addictions, obtain food and clothing, and look out for one another. Due to the deleterious impacts of chemicals contained in solvents, this group may suffer from additional mental health issues or health problems, and be more prone to being characterized as disruptive.

For some Aboriginal people—those who end up falling through the cracks—rejection or judgements that they face as Aboriginal people may be so overwhelming that they simply stop trying to get the help that they need. In most cases, it is simply that their cultural needs, experience and life history makes it difficult for Aboriginal people to access general services or for them to get the specific help that they need from them:

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[465] Taking note of the under-representation of Aboriginal people at shelters, despite their over-representation on the streets, the CARMHA recommended (at 101) an "[i]ncrease [in] the representation of Aboriginal staff at existing shelters and outreach programs to better engage Aboriginal clients" and an increase in the "population-specific housing and support services that target Aboriginal people and women."

[466] See the Supreme Court of Canada's discussion of prevalent stereotypes of Aboriginal peoples in *R. v. Williams*, [1998] 1 S.C.R. 1128 and *R. v. Gladue*, [1999] 1 S.C.R. 688.

> Many urban services designed for the general population are not culturally relevant to Aboriginal people. As a result, cultural and spiritual needs go largely unmet. Aboriginal people made a strong case for holistic services that recognize and work to heal the whole person. But most social and human services are designed to address specific problems, such as unemployment or child neglect and as such focus on symptoms rather than the underlying causes. Aboriginal people need and should have culturally appropriate services, designed by Aboriginal people, that promote healing through a holistic approach to individuals and communities.[467]

The Canadian Centre on Substance Abuse (the "CCSA") noted the contributions of successive government policies in creating high rates of addictions among the Aboriginal population:

> The erosion of a traditional way of life has had a negative impact on Aboriginal communities, families and individuals, including multi-generational losses of homeland, traditions, language and culture. This is rooted in government legislation (including the *Indian Act*), systematic racism and discrimination ... forced relocation, placement on reserves, and the historic impact of residential schooling. These experiences have affected the health and well-being of individuals, contributing to lower social and economic status, poorer nutrition, violence, crowded living conditions and high rates of substance abuse.[468]

Key differences between the Aboriginal and non-Aboriginal chronic alcoholic population in the DTES are posed as a constellation of factors that contribute to the high incidence of chronic alcoholism and addictions among Aboriginal people, which include:

(1) Cultural loss and disconnection: Aboriginal people living in urban settings such as the DTES are dislocated from their home communities. For some, this is the intergenerational result of Canadian government policies in the *Indian Act* which prevented Aboriginal women from remaining in their communities if they married non-Status men.[469] Most Aboriginal people who end up chronically addicted in the DTES are disconnected from their home communities, families and extended families. Cultural loss and dislocation is a key contributing factor which both results from, and sustains, their addictions;

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[467] RCAP, Vol. 4, *Perspectives and Realities*, at 554.
[468] Dell and Lyons, CCSA at 5.
[469] Aboriginal organizations spoke eloquently of the intergenerational impacts of this cultural dislocation. See also *Corbiere v. Canada (Minister of Indian and Northern Affairs)*, [1999] 2 S.C.R. 203, which discusses the importance of connection to Aboriginal home communities to those living in an urban environment.

(2) Impacts of the Indian Residential School System: Many Aboriginal chronic alcoholics are suffering from the intergenerational impacts of Indian Residential Schools ("IRS") and have been deeply harmed by their experiences, including physical, sexual and emotional abuse in IRS; The ongoing and intergenerational impacts of attendance at IRS are inexorably linked with the chronic addictions and mental health problems that many Aboriginal people face;[470] and

(3) Impacts (on both children and parents) of provincial Child Welfare Systems: Increasing numbers of Aboriginal people have experienced physical, sexual and emotional abuses, as well as dislocation from their families and cultures through the child welfare system.[471] Involvement with the child welfare system has long-term impacts which can contribute to addictions not only for those Aboriginal youth who were wards of the state but also the parents (particularly Aboriginal mothers who are street-involved) who have had their children taken and lost all contact with them.[472]

Ongoing Intergenerational Impacts Of Indian Residential Schools And The Child Welfare System

Aboriginal organizations and people emphasized the intergenerational impacts of the Indian Residential Schools (IRS) and child welfare systems as key contributing factors to the high prevalence of chronic addictions amongst the Aboriginal population. Many

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[470] The RCAP [Vol. 1: *Looking Forward, Looking Back*. (Ottawa: Royal Commission on Aboriginal Peoples, 1996) at 376–77] noted that:

> The schools were, with the agents and instruments of economic and political marginalization, part of the contagion of colonization. In their direct attack on language, beliefs and spirituality, the schools had been a particularly virulent strain of that epidemic of empire, sapping the children's bodies and beings. In later life, many adult survivors, and the families and communities to which they had returned, all manifested a tragic range of symptoms emblematic of 'the silent tortures that continue in our communities.' [References omitted].

See also Roland Chrisjohn, Sherri Young and Michael Mauran. *The Circle Game: Shadows and Substance in the Indian Residential School Experience in Canada* (Penticton: Theytus Books, 2006).

[471] For a discussion of the impacts of the child welfare system see: Union of BC Indian Chiefs. *Calling Forth Our Future: Options for the Exercise of Indigenous Peoples Authority in Child Welfare* (Vancouver: Union of BC Indian Chiefs, 2001); Representative for Children and Youth and Provincial Health Officer (joint report). *Health and well-being of children in care in British Columbia: Report 2 on educational experience and outcomes* (Victoria: Representative for Children and Youth and Provincial Health Officer, 2007); and Ted Hughes, *BC Children and Youth Review—Keeping Aboriginal Children Safe and Well* (Victoria: April 2006).

[472] Aboriginal women street workers reported that losing their children to the child welfare system remains an ongoing source of trauma in their lives which contributes to their addictions. Many reported that they do not know if their children are even alive and have had their access to their children terminated.

Aboriginal people who have gone through the IRS or child welfare systems find their way onto the streets suffering from addictions and mental health issues. IRS or child welfare system survivors were often not taught traditional cultural values, parenting or relational skills to help them in life, or even the everyday life skills to help them with banking or seeking shelter:

> Informants who work with Aboriginal peoples consistently noted a need for more life-skills workers. Several informants cited the trauma and intergenerational effects of the residential school system, and the need for life-skills/support workers to address these issues. Across the province, there is a need for more advocacy workers to help homeless [Substance Addicted Mentally Ill] individuals interface with the housing, health, income assistance, and legal systems.[473]

IRS survivors may have an aversion to institutions, and the degree of harm that people have suffered often means that it is impossible for them to seek services or assistance from any "institutional setting." Rules, time restrictions, religious elements may remind Aboriginal people of the conditions that they faced in IRS or other institutions (such as the child welfare system or while incarcerated) and make it traumatic for them to access these services. Situations such as line-ups, queues, being required to stay overnight (with no ability to leave a shelter once checked in), or having to listen to a sermon, may all remind Aboriginal people of their IRS experience and prevent them from accessing services. The religious aspects of some organizations may be particularly problematic for Aboriginal people who suffered physical, sexual or emotional abuse, and some report that being asked to go to a church-run service or shelter is like a re-victimization.[474]

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[473] CARMHA at 38.

[474] See, for example, Andrew Webster, *Sheltering Urban Aboriginal Homeless People: Assessment of Situation and Needs*, (Winnipeg: National Association of Friendship Centres and The Institute of Urban Studies, University of Winnipeg, 2007) at 36 ["Webster, *Sheltering*"]:

> The informants in this Study tended to have strong opinions about those mainstream shelters which require religious observance as a condition of assistance, or in which the goal of "salvation" is promoted in a less overt manner. The word "mission" often conjures up negative feelings among the operators and clients of Aboriginal shelters. Most Aboriginal people probably associate the word "mission" first and foremost with the church outposts which, from the early Post-Contact period, sought to convert Natives into Christians and sought to promote White values. The word "mission" is also inexorably linked with the former residential schools system. It would be unrealistic to think that historical associations like these do not stain the relationship between Aboriginal homeless people and church-run shelters.

Many IRS survivors choose to go without food or shelter rather than being forced to revisit this traumatic time in their lives. [475]

Lack Of Culturally Appropriate Services For Aboriginal Chronic Alcoholics

For the Aboriginal organizations and street-involved chronic alcoholic Aboriginal people whom we talked to, the lack of significant program funding for Aboriginal organizations was of critical importance. Given the large number of Aboriginal chronic alcoholics (including those with mental health and homelessness issues) the lack of Aboriginal-specific residential addiction treatment services in the DTES is surprising.

Cultural identity is an important factor in treating Aboriginal people with mental health and drug and alcohol addictions and most non-Aboriginal facilities do not offer the cultural safety many Aboriginal people need in order to confront and deal with the many complex issues they experience. The RCAP noted the need for culturally-based treatment and services for Aboriginal peoples who suffer from addictions:

> Alcohol addiction is seen by most health authorities—and by many of those who work in the treatment field—as a stand-alone problem with treatable causes. Some see it as a disease. Moreover, it is funded as a stand-alone problem with treatable causes. The most successful alcohol treatment programs developed by and for Aboriginal people have gone far beyond this restricted understanding of addictions; they have tackled related problems to physical and sexual abuse, loss of self-esteem and cultural identity, lack of personal opportunity and exclusion from mainstream Canadian society. Counselors have found that Aboriginal addictions are part of a circle of oppression, despair, violence, and self-destructive behaviors that must be addressed as a whole. [476]

Aboriginal peoples in an urban setting, such as Vancouver, are often isolated and experience racism and disconnection from their family and Aboriginal traditions. Many Aboriginal people are reluctant to access, or outright reject, services designed and

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[475] Webster, *Sheltering* at 36 (See also 37–40):

> The clearest indication that a mainstream shelter is unsuitable for Aboriginal people is when Aboriginal people refuse to go there even when they have no other place to sleep. The reasons for this unsuitability ... include honest inability to understand the culture and experiences of Aboriginal peoples, outright racism, and similarity of mainstream shelters to the residential schools.

[476] The RCAP, Volume 3, *Gathering Strength*, at 161.

delivered by non-Aboriginal people and are a significant part of the hardest to reach population. Often the people in the very situation Frank Paul was in—homeless alcoholics with mental health issues—will reject any non-Aboriginal solution.

Aboriginal people report that general service organizations often have no understanding of what Aboriginal cultures are, and why they are important. To get anywhere in solving the problems people face, it is necessary to understand why people are in the situation. The "why" for Aboriginal people is often quite different than for other people. Concurrent substance abuse and mental health issues, poverty and homelessness among Aboriginal people cannot be separated from the historic racism and inequities Aboriginal peoples have experienced.

Recommendations

These recommendations reflect the common points highlighted in our discussions with Aboriginal organizations and people. There was a great degree of concurrence about the changes that are necessary to meet the real and pressing needs of Aboriginal chronic alcoholics and substance users in the DTES.

1. There is a need for culturally appropriate services for Aboriginal chronic alcoholics in the DTES, designed and run by the Aboriginal community.

- Solutions for Aboriginal chronic alcoholics (many of whom are also homeless or mentally ill) need to be based on the recognition that the Aboriginal community has expertise which should be reflected in the creation of programs and services that match the real needs to Aboriginal people; and

- Funding support is needed to allow Aboriginal educational institutions (such as the Native Education Centre) to develop and offer educational programs to train Aboriginal drug and alcohol counselors and outreach workers to work with the chronically addicted Aboriginal population in the DTES.

The capacity to address the hardest to reach Aboriginal people and to take responsibility for the challenges they face is within the Aboriginal community itself and "[a]ny

discussion of harm reduction measures among Aboriginal peoples should start by recognizing that developing effective policies and programs must be founded and directed by communities and their members."[477] The Canadian Centre on Substance Abuse recognized that:

> Given the substance abuse-related harms faced by First Nations, Inuit and Métis in Canada, existing and emerging harm reduction services need to be culturally appropriate so they will be accessed. This includes incorporating Aboriginal culture, history and language into available and emerging services ... and increased awareness and understanding about Aboriginal peoples among service providers. There is an overarching absence of Aboriginal-focused resources and programming in the substance abuse field....
>
> It is suggested that ... Aboriginal culture, beliefs, traditions and practices be blended with current and emerging harm reduction services to make them as applicable and accessible as possible to all Aboriginal peoples. This must be done in collaboration with representatives of the relevant peoples.[478]

The Royal Commission on Aboriginal Peoples stated the rationale for Aboriginal community-based services in this way:

> In urban centres where Aboriginal people are present in large numbers or make up an important proportion of the overall population, Aboriginal service institutions should be seen as fundamental to service delivery, not as discretionary initiatives. In addition to providing greatly needed services, they are also important vehicles for supporting Aboriginal identity.... [S]ince they are directed and administered by Aboriginal people, service institutions are also working examples of the community of interest model of self-government in urban centres.[479]

Aboriginal organizations and people overwhelmingly and consistently highlighted the need for Aboriginal community-based control over the development, design and provision of programs and services to Aboriginal people.

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[477] Dell and Lyons, CCSA at 3.
[478] Dell and Lyons, CCSA at 14.
[479] RCAP, Vol. 4, *Perspectives and Realities*, at 555.

2. Create an Aboriginal Healing Centre designed and run by Aboriginal people in the DTES.

An Aboriginal Healing Centre might include:

(a) Space for those Aboriginal organizations that wanted to be housed there, to allow the Aboriginal Healing Centre to benefit from their combined expertise and experience and to allow clients easier access to a range of services;

(b) Programming that incorporates Aboriginal cultural philosophies and traditional healing practices;

(c) Aboriginal ceremonial and spiritual practices;

(d) An elders' support and guidance program;

(e) Programming aimed at sustaining or rediscovering cultural or traditional skills to address the sense of cultural dislocation that many chronically addicted Aboriginal people face;

(f) Land-based programming (some of which was offered outside of Vancouver and in Aboriginal communities) to help people recover their connections to land and Aboriginal communities, including access to traditional foods or medicines;

(g) Services aimed at addressing the specific issues that Aboriginal chronic alcoholics may face, such as a history of abuse through attendance at an IRS or involvement in the child welfare system; and

(h) Aboriginal cultural protocols of respect and caring to ensure that clients are provided a safe environment where they are treated humanely and with dignity and respect regardless of their condition or appearance, according to a holistic approach which focuses on the totality of an individual, and not just their addiction.

The creation of an Aboriginal Healing Centre in the DTES which would house several Aboriginal organizations and allow them to work collaboratively has long been a shared dream of Aboriginal organizations in the DTES. Proposals to create a DTES Aboriginal Healing Centre to address the complex issues faced by Aboriginal people are impeded by jurisdictional and funding disputes between various funding authorities.

3. There is a need for sustained and targeted funding proportional to the numbers of chronically addicted Aboriginal people in the DTES, for Aboriginal organizations that would allow the Aboriginal community to develop and maintain programs and services over the long term.

There is a lack of continuity and stability across Aboriginal organizations due to short-term contracting and chronic underfunding. The inability to secure long-term, predictable funding prevents most Aboriginal organizations from developing continuity in their planning. This creates gaps in services and often it is the most disorganized, unstable population represented by Aboriginal chronic alcoholics that falls through the cracks created by this system.

Available funding prevents an organic solution (grown from the life experiences of Aboriginal people and reflecting Aboriginal cultures) from developing. The experience of the Aboriginal organizations and people consulted showed that programs which are based on Aboriginal cultures and which incorporate Aboriginal peoples' voices and concerns have the greatest chance of success, yet there is a lack of separate funding sources for such programs. It is more common for governments and health authorities to design what they think is the appropriate program and then tell Aboriginal people what the plan is, rather than ask the Aboriginal community to design the program from the start. The RCAP noted the funding difficulties faced by Aboriginal organizations in urban settings such as the DTES:

> Current expenditures could also be made much more effective. Most funding for urban services is channeled through non-Aboriginal agencies. It is not at all clear that the Aboriginal community benefits as much as it might from these expenditures, especially given the likely absence of Aboriginal representatives on many agency boards. To begin relieving chronic underfunding and ensure that benefits are better targeted, we believe priority should be given to redirecting an appropriate share of existing expenditures to Aboriginal service agencies.[480]

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[480] RCAP, Vol.4, *Perspectives and Realities*, at 555–556. The lack of proportional funding to meet the needs of Aboriginal people was stated in this way in a report prepared for the National Association of Friendship Centres:

> Observation #1: The approaches of shelters for Aboriginal people, run by Aboriginal people, differ fundamentally from mainstream shelters; these differences make Aboriginal shelters more effective than mainstream shelters in assisting Aboriginal clients.

(footnote continued)

4. General service organizations should be required to show that they provide a culturally safe environment for Aboriginal people and that their staff is representative of the numbers of Aboriginal peoples whom they serve.

Where funding is provided to non-Aboriginal general service organizations it is not enough that they report Aboriginal peoples are part of their clientele. Aboriginal people may be excluded in the running or management of general service organizations, and are often not represented on the boards, or on the staff of these organizations. Organizations should not be able to get funding by including Aboriginal people in their client numbers simply because Aboriginal people could use their services—they should have to demonstrate that Aboriginal people actually do use their services.

5. Create a 24-hour Aboriginal drop-in centre in the DTES.

Services need to be available in the evenings or at night because this is when people need them. The programs or services currently available to help people in the DTES usually operate during expanded business hours. After 7:00 p.m. there are very few resources available to assist Aboriginal chronic alcoholics (particularly those who are homeless). There is no 24-hour drop-in centre in the DTES. Directions (formerly "Dusk to Dawn") operates a youth drop-in at St. Paul's Hospital but no such place exists for adults or that is geared towards Aboriginal people.[481]

Recommendation 1.1: "Aboriginal" funding for shelters should be divided into two streams: (1) The entire existing "Aboriginal" envelope should be reserved for the use of Aboriginal organizations delivering shelter services to Aboriginal people; (2) A modest proportion of the general envelope should be reserved for non-Aboriginal organizations delivering shelter services to Aboriginal people, and which can demonstrate a genuine and sufficiently large Aboriginal clientele as well as meet the caveats of Recommendation 1.2.

Recommendation 1.2: "Aboriginal" funding provided to non-Aboriginal shelter providers should have three principal caveats: (1) the provider must have a dedicated Aboriginal homelessness programme to which the funds must be 100% applied; (2) the programme must be designed and supervised by Aboriginal people; 3) the funding should be conditional upon the non-Aboriginal shelter securing a partnership with an Aboriginal organization with experience tin urban programme delivery. (Webster, *Sheltering* at 11–12)

[481] Although UNYA sends an outreach worker to Directions one day per week, the drop-in is largely underutilized by Aboriginal street youth because of the lack of Aboriginal people involved in the programming, staffing, and delivery of services.

Many chronic alcoholics who live on the street may sleep during the day when it is safest for them, and their awake time is after hours. There is no continuum of services through all hours of the day, most services are only available during extended office hours, and there are few services available overnight when the need is greatest.

The creation of a 24-hour Aboriginal drop-in centre to provide a safe place for Aboriginal homeless alcoholics to go overnight was a widely shared recommendation of Aboriginal people and organizations. The AFD would like to be able to provide a 24-hour drop-in centre for Aboriginal people in the DTES but funding issues, health and safety regulations, and space constraints prevent them from doing so right now. The AFD space is very small, but it is centrally located in the DTES and could provide a safe, warm environment where Aboriginal chronic alcoholics who are homeless could come and be given a place to stay overnight.

6. Offer solutions which do not require sobriety by providing a wet shelter or sobering centre for Aboriginal chronic alcoholics.

A non-judgmental and safe environment is needed that accepts that some people will not choose to give up drugs and alcohol, and that others who try to be abstinent may falter, but does not give up on them (i.e., does not blacklist them, or exclude them). This would be a real time solution to meet the needs of Aboriginal chronic alcoholics. The VPD, Saferide, or their peers could bring Aboriginal chronic alcoholics incapacitated on the street, or released from the jail, hospital, or detox, to a place where staff (which could include nurses or outreach workers) could monitor their condition through the night.

To be effective, any solution must accept Aboriginal chronic alcoholics and substance users “as is, where is.” In a continuum of services there are few services for chronic and severe alcoholics—sometimes described as “hard core”—who do not want to stop using. Aboriginal homeless chronic alcoholics are often barred from accessing services because their addictions and mental illness make it impossible for them to meet the threshold entrance criteria, and those who most need help cannot qualify for it.

Many Aboriginal organizations spoke of the need for immediacy of service. Aboriginal clients become lost in the process of referrals, wait lists and applications. The more bureaucratic or difficult services are to access, the less likely it is that Aboriginal chronic alcoholics will access them. Aboriginal people may additionally face compounding issues

of lack of (or low) literacy. Forms, the requirement for identification (which is often long since lost), or services that are accessed by automated phone systems all decrease the likelihood that people will be able to benefit from them.

Even where there is a referral service for appointments relatively close by, it is very difficult for people to get help as they will not make it even if the referral office is less than a block away. For example, the Courtworkers send someone weekly to the AFD to provide information about their services, and the AFD refers people to the Courtworkers the rest of the week. Even though the Courtworkers are only a block and a half away, there are many obstacles and temptations which can impede or distract a client away from their destination even if a Courtworker or counselor is available and waiting to meet them immediately.

7. Adopt an Aboriginal Housing First Strategy.

An Aboriginal Housing First Strategy designed to meet the immediate and long-term housing needs of Aboriginal people would provide a range of housing opportunities, including a no-barrier shelter facility for Aboriginal chronic alcoholics, as well as other housing options (with different levels of assistance and support) for clients able to live independently and in a less structured environment, including:

(a) A 24-hour, barrier-free, entry-level shelter to meet the immediate needs of Aboriginal chronic alcoholics that operates according to a harm reduction strategy and could include:

- a wet but safe shelter, which might include controlled access to alcohol; or
- a sobering centre which provides a safe place for people who were using to come to, and allows them to come and go as they choose but not to use in the facility.

The first intervention with chronic alcoholics, who are homeless or have mental health issues, needs to be where they are (the DTES), accept them

for who they are (active users of alcohol or substances), and provide immediate services;[482]

(b) Second stage supportive housing that Aboriginal people could transition through if they choose to progress through the recovery and healing process, or as their lives stabilize to allow them to be able to handle increasing degrees of independence in their housing; and

(c) Independent units which share common space and support services to allow people to be able to sustain an independent living arrangement.

The creation of safe and secure housing or shelter is a necessary preliminary step in helping Aboriginal chronic alcoholics. This population is among the hardest to house and many are homeless. The lack of a secure home base increases the risk (of exposure, and violence, and so forth) that this population faces and adds to the lack of stability in their lives, which may in turn amplify and sustain their addictions.

A continuum of housing services is necessary to allow chronic alcoholics or substance users to stabilize their lives and seek help for any mental health issues that they experience. If, in the long term, chronic alcoholics or substance users choose to stop or reduce their substance use different stages of housing are needed. Currently, even if a person chooses to reduce or stop their alcohol or substance use, if they do not have a home or place to go they end up in the same environment, facing the same temptations.

An Aboriginal Housing First strategy would:

- Provide culturally appropriate program and support services that address issues particular to Aboriginal people such as cultural dislocation and identity loss and the intergenerational impacts of the IRS and child welfare systems;

- Involve Aboriginal people, including youth, elders, women and men, in the conceptualization and design. This would increase a sense of ownership and care for the facility in the long-term and ensure that it met the actual (and not imagined) needs of Aboriginal people;

[482] In a continuum of services, a 24-hour drop-in centre (discussed in recommendation 5) would be a precursor to this type of shelter facility, as it would provide a safe space for Aboriginal chronic alcoholics to be overnight, and while it may provide chairs for people to sleep in or shower facilities, it would not have beds.

- Provide opportunities for Aboriginal people to maintain their family and relationships, such as co-ed or communal spaces where couples or other street-families could access services together. For example, if a person has an intimate relationship, created a street family or belongs to a "Listerine Gang" services need to be tailored to attract the whole group, not simply targeting the individual;

- Provide a safe and secure space for people to store their belongings. If the contents of a shopping cart are all that people own, and if they cannot keep it safe, they will not go to shelters or access services. Safe spaces to store possessions (such as a locker or locked shopping cart storage stalls) are needed;

- Ensure there are a sufficient number of outreach workers in the DTES to find and assist Aboriginal people in need to the facility;[483] and

- Have support teams which work with clients over the long term in a holistic fashion and link the counseling or treatment, life skills training, education, medical, cultural, spiritual, and follow-up needs of each client.

CARMHA recognized the overrepresentation of Aboriginal people among the substance-abusing, mentally ill homeless population and recommended the creation of a supportive housing option that responds to Aboriginal peoples' unique cultural and healing needs:

> Aboriginal homeless services must be culturally appropriate and controlled by Aboriginal services providers in order to be effective. One could envision Aboriginal supported housing that contains a communal area (based on the long-house concept for example) where tenants could practice their culture and rituals on-site; liaison workers who specialize in providing mental health and addictions treatment to this population.... While current services tend to treat the individual, the Aboriginal perspective would address the health of the entire community, and how it affects the individual. Moreover, the role of elders should not be overlooked, as they are highly respected among First Nations people; they could play a significant role in addressing the multi-faceted problems of homelessness even if they are not formally recognized by mainstream social service agencies.... Housing and support geared towards Aboriginal peoples would help create a sense of spiritual and cultural belonging, which is lacking for many Aboriginal peoples.[484]

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[483] The Aboriginal Native Health Centre in Toronto operates a Shelter Bus which picks up people and helps them find shelters.

[484] CARMHA at 64 (References omitted).

Aboriginal people represent a disproportionate amount of the provincial population which is in "core housing need" or absolutely homeless.[485] Even though there are approximately 24 Aboriginal social housing complexes in East Vancouver, they only manage to fill a small portion of Aboriginal housing needs and are not equipped to deal with the specific housing needs of chronically addicted people, particularly those who suffer from concurrent mental health issues. The majority of the Aboriginal social housing units that do exist are located outside of the core of the DTES, and only one unit is located on Powell Street near to the core of the DTES.

Given the great demand for housing, people who suffer from chronic and severe addictions and whose behavior is often considered bizarre or disruptive, are least likely to be able to access social housing units, and more likely to face eviction. When the need is so great, housing societies can afford to be selective with their tenants, and are more likely to choose tenants who will not cause a disruption. Social housing and Single Room Occupancy ("SRO") housing may help support people on the borderlines, but do not address the real difficulty for Aboriginal chronic alcoholics who are unable to maintain housing.

8. Services provided to Aboriginal chronic alcoholics should include services for those with concurrent mental health issues.

Many Aboriginal chronic alcoholics also suffer from concurrent mental disorders. Chronic substance abuse or a life on the streets can exacerbate or create further difficulties. Aboriginal women who work the streets, for example, report that violence and abuse that they suffer on the streets can traumatize them and add to the need for mental health services. The situation of chronic alcoholics (particularly those who are homeless) is further complicated because it is difficult to get the psychiatric diagnosis necessary for funding and treatment. Aboriginal chronic alcoholics with mental health issues may not want to be diagnosed, or have difficulty with keeping their appointments, be unable to report on their medical history or have difficulty in maintaining a medication regimen. Any facility must incorporate mental health professionals willing to work where people are, because they will not access services otherwise, and addressing

[485] British Columbia Office of Housing and Construction Standards, Housing Policy Branch. *Developing an Off-Reserve Aboriginal Housing Action Plan for British Columbia: A Discussion Paper to Support Community Engagement* (January 2008).

mental health issues is an important component in helping people to address their addictions.

9. A sustained and independently monitored process is needed to improve the relationship between the Aboriginal community in the DTES and the Vancouver Police Department.

We did not specifically ask about the relationship between the VPD and Aboriginal people but this was consistently raised as an issue and Aboriginal people and organizations reported that this relationship is very poor and fractured. In overwhelming numbers, Aboriginal chronic addicts reported personal experiences of violence or harassment by the police, and felt that they were targeted more (and treated worse) by the VPD than their non-Aboriginal peers.[486]

The Aboriginal people and organizations consulted made several suggestions for improving the relationship between the VPD and the Aboriginal community in the DTES, including:

(a) Hiring more Aboriginal and women police officers;

(b) Creating an independent (not tied to the VPD) Aboriginal liaison between the Aboriginal community and the VPD in the DTES;

(c) Creating a "Watchdog" position or office to monitor the VPD's relationship with Aboriginal people in the DTES, empowered to pursue and investigate complaints of police harassment or brutality, and tasked with ensuring that police reports filed by Aboriginal people are treated seriously; and

(d) Having a special VPD "Aboriginal car" which would be visibly distinct and have Aboriginal officers or community-based liaison workers patrolling with VPD officers in the DTES.

Instead of seeking help or protection from the VPD, Aboriginal people were frightened of the VPD and tried to actively avoid VPD officers for fear of harassment or violence. Even

[486] Although not part of the research we were tasked with, it was particularly concerning that Aboriginal people and organizations consistently reported violence at the hands of a particular team of plain clothes VPD officers. There were multiple reports (at different organizations and by different Aboriginal people) of extreme brutality, which seemed to identify the same pair of officers.

though the VPD has an Aboriginal Community Policing Centre (1726 East Hastings) Aboriginal people reported that it was not well used as people were afraid or distrustful of any contact with the VPD. Many people refuse to report incidents of violence or abuse because they are afraid of being disbelieved or subjected to even worse treatment at the hands of the VPD.

Fear of the police puts Aboriginal homeless chronic alcoholics in a particularly vulnerable position to being victimized. Several Aboriginal women who are chronic alcoholics report being sexually assaulted and beaten but were too afraid of the police, or believed that nothing would be done and that their complaint would be dismissed, to report these incidents. The fact that a large number of Aboriginal women went missing from the DTES (and many were subsequently found murdered) and that the growing number of disappearances did not appear to be taken seriously by the VPD continues to haunt the DTES Aboriginal community's relationship with the VPD.

Conclusion

It matters that Frank Paul was a Mi'kmaq man. Aboriginal people are overrepresented in the chronically addicted population in the DTES, and are the most vulnerable of the vulnerable: they are less likely to seek (or receive) help and more likely to be victims of violence and discrimination.

Aboriginal organizations and people reported a number of barriers that impede Aboriginal chronic alcoholics from accessing existing services and prevent Aboriginal organizations from developing comprehensive culturally relevant services for Aboriginal chronic alcoholics in the DTES. General service organizations often have no understanding of what Aboriginal cultures are, and why they are important.

Concurrent substance abuse and mental health issues, poverty and homelessness among Aboriginal people cannot be separated from the historic racism and inequities Aboriginal peoples have experienced. A confluence of historic and social factors contribute to the large numbers of chronic Aboriginal addicts in the DTES, including cultural loss and dislocation, and the intergenerational impacts of the IRS and child welfare system.

Many of the Aboriginal organizations and people share a vision for what is needed to improve the situation of Aboriginal chronic alcoholics (many of whom are also homeless or have mental health issues) in the DTES. The main shared recommendations were for:

(1) The creation and sustained funding of Aboriginal community-based programming for Aboriginal chronic alcoholics in the DTES which incorporate Aboriginal cultural values and healing practices into existing and emerging services;

(2) The creation of an Aboriginal Healing Centre in the DTES;

(3) Sustained and long-term funding for Aboriginal community-based solutions for Aboriginal chronic alcoholics in the DTES that is proportional to the numbers of Aboriginal people in the DTES (approximately 40% of all available government funding should be targeted to Aboriginal community-based organizations);

(4) Requiring general service organizations to show that they provide culturally safe services that Aboriginal people can access, and that their staff and management is representative of the numbers of Aboriginal people whom they serve in order to receive funding where they include Aboriginal peoples in their client count;

(5) The creation of a 24-hour drop-in centre for Aboriginal chronic alcoholics in the DTES;

(6) Services that do not require sobriety in order to help Aboriginal chronic alcoholics, such as a wet shelter or sobering centre;

(7) Adoption of an Aboriginal Housing First strategy to provide different levels of housing ranging from a harm reduction component (such as a wet shelter or sobering centre) through to independent living units in a culturally appropriate and supportive environment which would provide the stability chronic alcoholics need; and

(8) A sustained and independently monitored process to improve the relationship between the VPD and the Aboriginal community in the DTES was very important, as this fractured relationship contributes to the risk of harm and violence that Aboriginal peoples experience.

Given current demographics, the growing number of Aboriginal youth makes it likely that the chronically addicted Aboriginal population in the DTES will grow in the foreseeable future. To avoid future deaths such as Frank Paul's it is necessary to act now by ensuring that Aboriginal people are actively involved in culturally appropriate solutions tailored to meet the specific needs of Aboriginal chronic alcoholics in the DTES.

Appendix a—Aboriginal Voices

Aboriginal organizations that we met with to learn about the services that they offer and their recommendations for what is needed:

- Vancouver Aboriginal Wellness Program (Barbara Keith, Director)
- Vancouver Native Health Society (Lou Demerais, Executive Director)
- Aboriginal Front Door Society (Stan Parenteau, Director)
- Aboriginal Front Door Society (General Community Meeting, 19 participants)
- Aboriginal Front Door Society (Women's Community Meeting, 9 participants)
- Native Courtworker and Counseling Association of BC—Vancouver Region (Art Paul, Regional Manager)
- United Native Nations—Vancouver Local (David Dennis, Vice-President)
- Pacific Association of First Nations Women (Ruth Alfred, Elder Support Worker and Sandra Greene, Community Health Liaison Coordinator)
- Aboriginal Homelessness Steering Committee (Patrick Stewart, President)
- Hey'-Way'-Noqu Healing Circle for Addictions (Marie Anderson, Executive Director)
- Vancouver Aboriginal Friendship Centre (Susan Tatoosh, Executive Director; Sherry Small, Program Director; Gerry Adams)
- Urban Native Youth Association (Bob Manning, Coordinator/Alcohol and Drug Counselor)

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