

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

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.¹

There were other VPD “responses” as well, such as the convening of an advisory committee involving the department and members of the Aboriginal community, 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.² 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

¹ 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.

² Transcript, Jan. 30, 2008, pp. 73–75.

to, and there was no evidence of what these measurements were or what happened to them.³

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.⁴ 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 his involvement was more a matter of recording the circumstances of a death by hypothermia, than a criminal investigation.⁵

The lead investigator in the criminal investigation was Det. Doug Staunton.⁶ 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

³ Transcript, Jan. 30, 2008, pp. 128–29, 133.

⁴ Transcript, Jan. 30, 2008, pp. 79–80, 83–86, 88, 93.

⁵ Transcript, Jan. 30, 2008, pp. 119–21; 123–24.

⁶ 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.

Frank Paul’s death. After completing the criminal investigation into Mr. Paul’s death, he prepared the Report to Crown Counsel in the matter.⁷

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.⁸ 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.

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.⁹ He had very little involvement in the investigation otherwise.¹⁰

b. Attendance at the autopsy

On December 8, 1998, Det. Staunton attended the autopsy.¹¹ His usual Homicide partner, Det. Constable Mike Cumberworth, also attended the autopsy but had no other involvement in the criminal investigation.¹²

⁷ Transcript, Feb. 14, 2008, pp. 2–3, 6.

⁸ Transcript, Feb. 14, 2008, pp. 19–28.

⁹ Transcript, Feb. 14, 2008, p. 29.

¹⁰ 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.

¹¹ Transcript, Feb. 14, 2008, p. 37.

¹² Transcript, Feb. 14, 2008, p. 5.

(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.¹³

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.¹⁴ 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. 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.¹⁵

I heard from many witnesses whose present recollection was minimal, and who relied heavily on their initial written statements. Had those

¹³ Transcript, Jan. 30, 2008, pp. 73–75, 81–85.

¹⁴ Transcript, Feb. 14, 2008, pp. 18–19, 55–56.

¹⁵ Transcript, Feb. 14, 2008, p. 57.

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

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:¹⁶

- 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

¹⁶ Transcript, Feb. 21, 2008, pp. 9–19.

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.¹⁷
- 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.
- 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.¹⁸

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

¹⁷ Transcript, Feb. 14, 2008, pp. 30–31; he noted the area was more industrial although a low-level apartment building was nearby.

¹⁸ 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.

refused entry.¹⁹ 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 1999.²⁰ 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.²¹ 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.²²

The report—itself an exhibit in our proceedings²³—assembles all the various witness statements and the evidence gathered. It offers a 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,²⁴ 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.²⁵ 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

¹⁹ Transcript, Feb. 14, 2008, pp. 46–47.

²⁰ Exhibit 91.

²¹ Transcript, Feb. 14, 2008, pp. 6–7.

²² Transcript, Feb. 14, 2008, pp. 53–54.

²³ Exhibit 91.

²⁴ 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.

²⁵ Transcript, Feb. 14, 2008, p. 15.

match the elements of those offences.²⁶ 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.²⁷ Det. Staunton tried repeatedly for four months, before obtaining Cst. English’s duty report statement.²⁸

On December 21, 1999, Crown Counsel Michael Hicks wrote to Insp. Biddlecombe, informing him that no criminal charges would be forthcoming.²⁹ 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).³⁰

²⁶ Transcript, Feb. 14, 2008, pp. 17, 107–08.

²⁷ Transcript, Feb. 14, 2008, pp. 60–63; Det. Staunton also played the video of the Jail for Mr. Cullen.

²⁸ Transcript, Feb. 14, 2008, pp. 95–102.

²⁹ 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.

³⁰ Transcript, Feb. 14, 2008, p. 9.

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

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.³¹

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.³² 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 do not get laid so that there’s not any kind of perception of bias or subjectivity on the part of the police.³³

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.”³⁴

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.

³¹ Transcript, Feb. 14, 2008, p. 10.

³² 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.

³³ Transcript, Feb. 21, 2008, pp. 34–35.

³⁴ Transcript, Feb. 21, 2008, p. 51.

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.³⁵ 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.³⁶ 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.³⁷

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.³⁸ While it is an inevitable reality of criminal investigations that there will be inconsistencies in the evidence,³⁹ 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

³⁵ Transcript, Feb. 27, 2008, pp. 17–21.

³⁶ Transcript, Feb. 21, 2008, pp. 37–38.

³⁷ Transcript, Feb. 14, 2008, pp. 75–76.

³⁸ 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.

³⁹ Transcript, Feb. 14, 2008, p. 79.

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.⁴⁰

Insp. Porteous, head of the VPD’s Major Crimes Section, confirmed that reliance on duty reports for police statements appears to be the norm.⁴¹ 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.⁴²

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:

⁴⁰ Transcript, Feb. 27, 2008, pp. 17–21; see also Affidavit of A. Boyd, Exhibit 196, para. 14.

⁴¹ Transcript, Feb. 21, 2008, pp. 26–27.

⁴² Transcript, Feb. 21, 2008, p. 28.

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

- 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, 1999.⁴³ 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.

⁴³ 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.

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

Sgt. Hobbs tried to contact Cst. English on several occasions to have him provide a statement.⁴⁴

Sgt. Hobbs also made efforts to learn if Mr. Paul had an address in Vancouver. He did not find one.⁴⁵ 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.⁴⁶ He characterized the complaint as a “public trust complaint” and received confirmation that the PCC agreed with that characterization.⁴⁷

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.⁴⁸

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

⁴⁴ 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.

⁴⁵ Transcript, Feb. 13, 2008, p. 17.

⁴⁶ Exhibit 110, Tab B.

⁴⁷ Transcript, Feb. 13, 2008, pp. 27–29; Exhibit 110, Tab C.

⁴⁸ Transcript, Feb. 13, 2008, p. 32.

three years of his career (from 1999 to 2003) in the Internal Investigation Section.⁴⁹

Sgt. Boutin⁵⁰ 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.⁵¹

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.⁵²

When Sgt. Boutin assumed conduct of the Frank Paul file in September 1999,⁵³ the professional standards investigation had to be completed by

⁴⁹ Transcript, Feb. 11, 2008, p. 2.

⁵⁰ 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.

⁵¹ Transcript, Feb. 11, 2008, pp. 4–5.

⁵² Transcript, Feb. 11, 2008, pp. 5–7, 9.

⁵³ Evidence of A. Hobbs, Transcript, Feb. 13, 2008, p. 31.

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

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, 2000.⁵⁴

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*.⁵⁵

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.⁵⁶ In the Frank Paul case, of course, such 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.⁵⁷ He reviewed Sgt. Sanderson’s second written statement on the Paul matter, dated

⁵⁴ 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.

⁵⁵ Transcript, Feb. 11, 2008, pp. 10–11.

⁵⁶ Transcript, Feb. 11, 2008, pp. 12–14.

⁵⁷ Transcript, Feb. 11, 2008, pp. 45–50.

February 17, 2000.⁵⁸ He also sought information from Environment Canada about the weather conditions on December 5–6, 1998.⁵⁹

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?⁶⁰

Counsel for Cst. Instant responded with four “no” answers, and nothing more. There was no further discussion.⁶¹

Although the memo containing the four questions was also addressed to Sgt. Sanderson, Sgt. Boutin was not sure he actually sent it to 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.⁶²

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.”⁶³ The *Police Act* provided for up to five days’ suspension (but no more), and

⁵⁸ Transcript, Feb. 11, 2008, p. 51.

⁵⁹ Transcript, Feb. 11, 2008, pp. 50–51; Exhibit 110, Tabs P, U.

⁶⁰ Exhibit 110, Tab J.

⁶¹ Transcript, Feb. 11, 2008, p. 39; Exhibit 110, Tab R.

⁶² Transcript, Feb. 11, 2008, pp. 37–38.

⁶³ Transcript, Feb. 11, 2008, p. 44.

Sgt. Boutin did not feel this case involved the worst sort of conduct, warranting the maximum length of suspension.⁶⁴

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*.”⁶⁵

Sgt. Boutin explained that someone else (he did not recall who) suggested the “management advice” approach, and he initially agreed it would be adequate.⁶⁶ 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 anticipated.⁶⁷ Upon looking at the file in greater detail, however, Sgt. Boutin concluded it would not be appropriate.⁶⁸

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.⁶⁹

⁶⁴ Transcript, Feb. 12, 2008, p. 167.

⁶⁵ Transcript, Feb. 12, 2008, p. 165.

⁶⁶ Transcript, Feb. 11, 2008, p. 18–20.

⁶⁷ 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.

⁶⁸ Transcript, Feb. 11, 2008, pp. 18–20.

⁶⁹ 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.

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.⁷⁰ 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.⁷¹ He recommended a one-day suspension without pay.

For both officers, Sgt. Boutin noted that he did not conclude there was malice or culpable intent.⁷²

In addition, Sgt. Boutin made a recommendation to the department’s Planning and Research Section,⁷³ 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.⁷⁴

⁷⁰ Transcript, Feb. 11, 2008, p. 59; Exhibit 110, prior to Tab A, p. 6.

⁷¹ Transcript, Feb. 11, 2008, p. 60; Exhibit 110, prior to Tab A, p. 6.

⁷² Transcript, Feb. 11, 2008, p. 60.

⁷³ Transcript, Feb. 11, 2008, pp. 24–25, 57; Exhibit 110, prior to Tab A, p. 7 (numbering added).

⁷⁴ Transcript, Feb. 12, 2008, pp. 185–86; Exhibit 110, Tabs X, GG.

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

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.⁷⁵

In his handwritten notation dated February 15, 2000, Chief Blythe indicated his agreement with Sgt. Boutin’s report and indicated: “The penalty must align with similar fact evidence [*sic*] and penalty recommendations.”⁷⁶

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.⁷⁷ On June 20, 2000, Sgt. Sanderson accepted the proposed disciplinary measures, a two-day suspension without pay.⁷⁸

The Internal Investigation Section closed its file on June 28, 2000, and advised the PCC.⁷⁹

⁷⁵ Transcript, Feb. 27, 2008, pp. 7–16, 23, 45–46.

⁷⁶ 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.

⁷⁷ Transcript, Feb. 11, 2008, p. 63.

⁷⁸ Transcript, Feb. 12, 2008, pp. 154–55.

⁷⁹ Transcript, Feb. 11, 2008, p. 67; Exhibit 110, Tab FF.

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.

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

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

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.⁸⁰ 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.⁸¹ 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.⁸²

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....

Although the VPD offered no apology to the Paul family, during Chief Constable Blythe’s tenure,⁸³ for its treatment of Frank Paul, Chief Constable Graham did offer an apology in 2004.⁸⁴

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.⁸⁵

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

⁸⁰ Transcript, Feb. 21, 2008, pp. 138–63; Exhibits 147, 148, 149.

⁸¹ Transcript, Feb. 14, 2008, pp. 166–67.

⁸² Transcript, Feb. 14, 2008, pp. 168–70.

⁸³ Transcript, Feb. 27, 2008, pp. 66–67.

⁸⁴ Exhibit 147, Tab 23, letter of Apr. 28, 2004, to City Manager, City Of Vancouver; see also Tab 7.

⁸⁵ Transcript, Jan. 11, 2008, p. 54.

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

consider the broad issue, and develop a policy that would permit an apology to be provided in such a situation