

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

### **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,<sup>1</sup> enacted in 2007, made significant changes to the Act<sup>2</sup> 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, 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<sup>3</sup>**

- a. Attendance at the scene of Mr. Paul’s death

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<sup>1</sup> See *Coroners Act*, [Statutes of British Columbia] S.B.C. 2007, c. 15, which came into force on September 26, 2007.

<sup>2</sup> See *Coroners Act*, [Revised Statutes of British Columbia] R.S.B.C. 1996, c. 72.

<sup>3</sup> 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.

Although Mr. Paul’s body was discovered in the alleyway near the Detox Centre at approximately 2:30 a.m., Donna Lister,<sup>4</sup> 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.<sup>5</sup>

**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,<sup>6</sup> who had the authority to sign such a report.<sup>7</sup> 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.<sup>8</sup>

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.<sup>9</sup>

**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.<sup>10</sup>

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<sup>4</sup> 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.

<sup>5</sup> Transcript, Nov. 30, 2007, pp. 2–9.

<sup>6</sup> Exhibit 53 (also Exhibit 90, Tab 4).

<sup>7</sup> Transcript, Jan. 23, 2008, p. 54.

<sup>8</sup> Transcript, Nov. 30, 2007, pp. 10–12, 15.

<sup>9</sup> Transcript, Nov. 30, 2007, p. 30.

<sup>10</sup> Transcript, Nov. 30, 2007, p. 9.

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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.<sup>11</sup>

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 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.<sup>12</sup>

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.<sup>13</sup> 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.<sup>14</sup>

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<sup>11</sup> Transcript, Jan. 16, 2008, pp. 1, 8–9; Exhibits 84, 85, and 86.

<sup>12</sup> Transcript, Jan. 16, 2008, pp. 24–25, 34–48.

<sup>13</sup> Transcript, Jan. 16, 2008, pp. 49–51, 55, 58.

<sup>14</sup> Exhibit 90, Tab 3.

In her report, Dr. Gray described the cause of death as “[h]ypothermia due to or as a consequence of acute alcohol intoxication.”<sup>15</sup> 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:<sup>16</sup>

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.

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.<sup>17</sup>

Dr. Butt suggested there was “a reasonably good possibility that he would have seizures.”<sup>18</sup>

Dr. Butt described two medical conditions that would often arise for chronic alcoholics such as Mr. Paul. One is peripheral neuritis, an

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<sup>15</sup> Transcript, Jan. 16, 2008, pp. 19–23; Exhibit 85 (also Exhibit 90, Tab 44).

<sup>16</sup> Transcript, Jan. 16, 2008, p. 23.

<sup>17</sup> Transcript, Mar. 19, 2008, pp. 7–11; Exhibit 161, pp. 2–3.

<sup>18</sup> Transcript, Mar. 19, 2008, p. 32.

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<sub>1</sub> 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.<sup>19</sup>

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 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.<sup>20</sup>

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.<sup>21</sup> 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.

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<sup>19</sup> Transcript, Mar. 19, 2008, pp. 13, 16–19, 40, 45–52, 93.

<sup>20</sup> 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.”

<sup>21</sup> Exhibit 90, Tab 45; see also Tab 54 (current policy).

The regional coroner, Jeannine Robinson,<sup>22</sup> 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.”<sup>23</sup>

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 determination on the matter; he was providing advice rather than issuing a directive.<sup>24</sup> Ms. Robinson, however, testified that she took this as a directive.<sup>25</sup> 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.<sup>26</sup>

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,

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<sup>22</sup> 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.

<sup>23</sup> Transcript, Jan. 23, 2008, pp. 71–73 and p. 75 (quotation); see also p. 144.

<sup>24</sup> Transcript, Jan. 25, 2008, pp. 3–8, 41–42.

<sup>25</sup> Transcript, Jan. 23, 2008, p. 75.

<sup>26</sup> Transcript, Jan. 25, 2008, pp. 85–87, Exhibit 93, p. 5.

she conveyed this to Ms. Lister and to Sherryl Yeager, the deputy regional coroner.<sup>27</sup>

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.<sup>28</sup> 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.<sup>29</sup> 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.<sup>30</sup>

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<sup>31</sup>:

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,

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<sup>27</sup> Transcript, Jan. 23, 2008, pp. 73–76.

<sup>28</sup> Transcript, Jan. 23, 2008, p. 67.

<sup>29</sup> Transcript, Jan. 23, 2008, pp. 77–83.

<sup>30</sup> Transcript, Jan. 23, 2008, pp. 78–80; Transcript, Jan. 24, 2008 pp. 15–16.

<sup>31</sup> 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.

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:<sup>32</sup>

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 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:<sup>33</sup>

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

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<sup>32</sup> Transcript, Jan. 24, 2008 pp. 139–45 (quotation p. 145).

<sup>33</sup> Exhibit 90, Tab 43.

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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:<sup>34</sup>

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 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.”<sup>35</sup>

### **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

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<sup>34</sup> Exhibit 90, Tab 43.

<sup>35</sup> Transcript, Jan. 23, 2008, pp. 49–51.

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.<sup>36</sup> It is clear that in this case the Coroners Service did not notify Mr. Paul’s next of kin.<sup>37</sup>

The current chief coroner, Terry Smith, was unequivocal about the responsibility to notify and consult with the next of kin. He testified:<sup>38</sup>

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 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.

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<sup>36</sup> 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.

<sup>37</sup> 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.

<sup>38</sup> 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.

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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.<sup>39</sup> On December 11, 1998, she publicly identified the deceased as Frank Paul, 47 years old, of “no fixed address.” She stated that there was no clear cause of death, and that toxicology results would be some weeks away.<sup>40</sup>

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.<sup>41</sup> 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

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<sup>39</sup> 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.

<sup>40</sup> Transcript, Feb. 13, 2008, pp. 88–92, 95–101, 137.

<sup>41</sup> Transcript, Feb. 13, 2008, p. 103.

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.<sup>42</sup>

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.<sup>43</sup>

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 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.<sup>44</sup>

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,<sup>45</sup> and agreed that his role may have been contacting the next of

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<sup>42</sup> Transcript, Feb. 14, 2008, pp. 33–34.

<sup>43</sup> Transcript, Jan. 23, 2008, pp. 58–60.

<sup>44</sup> Transcript, Feb. 13, 2008, pp. 149–53.

<sup>45</sup> Transcript, Feb. 13, 2008, pp. 151, 158–60, 162–64.

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kin in order to arrange the return of Mr. Paul’s body, as distinct from contacting them to tell them of his death.<sup>46</sup>

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.<sup>47</sup> He testified that when Frances got home, he told her what the caller had told 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.<sup>48</sup>

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.<sup>49</sup>

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.<sup>50</sup>

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<sup>46</sup> Transcript, Feb. 13, 2008, p. 176.

<sup>47</sup> Transcript, Feb. 26, 2008, pp. 55–58.

<sup>48</sup> Transcript, Feb. 26, 2008, pp. 57–58.

<sup>49</sup> Transcript, Feb. 26, 2008, pp. 67–70.

<sup>50</sup> Transcript, Feb. 26, 2008, pp. 72–74, 77.

#### 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.<sup>51</sup>

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.<sup>52</sup> 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."<sup>53</sup> 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

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<sup>51</sup> Transcript, Jan. 31, 2008, pp. 122–23.

<sup>52</sup> Transcript, Jan. 31, 2008, p. 23; Exhibit 110, Tab XX (letter from R. Rothwell to B. Murphy, October 10, 2002).

<sup>53</sup> Transcript, Jan. 31, 2008, pp. 25–26.

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.”<sup>54</sup>

### **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.<sup>55</sup> He renewed that request in 2001. In 2004, a different PCC (Dirk Ryneveld) made a similar request.

The legislation in force at those times<sup>56</sup> 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 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.<sup>57</sup>

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

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<sup>54</sup> Transcript, Jan. 31, 2008, pp. 27, 12–13, 41–43.

<sup>55</sup> Transcript, Jan. 23, 2008, pp. 146–47.

<sup>56</sup> *Coroners Act*, R.S.B.C. 1996, c. 72, s. 20(6).

<sup>57</sup> Transcript, Jan. 28, 2008, pp. 4–9.

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.<sup>58</sup>

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.<sup>59</sup>

## **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.<sup>60</sup> These notes would be expected 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.<sup>61</sup>

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

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<sup>58</sup> Transcript, Jan. 23, 2008, pp. 96–98; see also Evidence of T. Smith, Transcript, Jan. 28, 2008, pp. 25–29.

<sup>59</sup> Transcript, Jan. 28, 2008, pp. 31–33, 70, 86.

<sup>60</sup> Transcript, Jan. 23, 2008, pp. 65–67.

<sup>61</sup> 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.

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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:

- 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,<sup>62</sup>
- Deputy Chief Coroner Norm Leibel agreed that, with the benefit of hindsight, he would “absolutely” take the Paul case to inquest,<sup>63</sup> 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.<sup>64</sup>

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.

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<sup>62</sup> Transcript, Jan. 25, 2008, pp. 85, 8.

<sup>63</sup> Transcript, Jan. 29, 2008, p. 24.

<sup>64</sup> Transcript, Jan. 28, 2008, pp. 15–16.

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, 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

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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.