

# **Appendix K**

## **Participant Submissions**

### **Summary and Overview**

I wish to acknowledge and express my appreciation for the hard work of the participants who appeared before me. As indicated in Part 2 of my report, some 14 participants appeared by counsel.

Counsel for the participants participated in the cross-examination of witnesses called by Commission Counsel. I made no formal order respecting the order of cross-examinations or the length of cross-examinations. Counsel were able to cooperate and agree upon the order of cross-examination and worked hard to avoid duplication and repetition and focused on matters of concern to their particular clients. I appreciate that depending upon counsel to address and solve the inevitable daily issues of scheduling, sequencing and economy of effort placed a heavy burden on them. As a result however, I found my work proceeded much more smoothly and efficiently.

### **Institutional Participants**

The Terms of Reference required me to inquire into and report on the response of the Vancouver Police Department and Police Board, the BC Ambulance Service and Emergency Health Services Commission, the BC Coroners Service, the Criminal Justice Branch, the Ministry of Attorney General and the four police complaint commissioners who held office during the consideration of the Paul matter.

Without exception these institutional participants made witnesses available to counsel for the Commission, cooperated in the scheduling of our work and were fair and forceful in representing the interests of their clients. I am particularly indebted to counsel for the Vancouver Police Department, who had the lion's share of the burden of arranging for the attendance of witnesses.

Finally, I want to acknowledge that each institutional participant looked carefully at the facts and acknowledged mistakes where they believed mistakes had been made and provided invaluable input with respect to what changes had been made since the death of Frank Paul and addressed potential ways of improvement. Although I have not in many cases accepted their view of the problem or appropriate solutions, my thinking has been assisted greatly by the participation of these expert and hardworking professionals.

### **Public Interest Participants**

It was vital to the full airing of the issues that arose from the facts that participants who represented the interests of the Paul Family, the First Nations community, and the general public were able to obtain the resources to participate fully in the work of the commission. The Paul Family were able to participate throughout by counsel and their participation was gracious and measured. The First Nations Leadership Council and the United Native Nations Society both dedicated themselves to exploring the ways in which the facts surrounding Frank Paul's life and death needed to be understood from an Aboriginal perspective. Aboriginal Legal Services of Toronto participated throughout and were disciplined and thorough in helping me assess particularly the ways in which the institutional methods of dealing with Aboriginal persons failed to account for their distinctive needs. Finally, the BC Civil Liberties Association brought their customary passion to preserving our civil liberties and enhancing our civil society to bear on the evidence and policy issues.

In this appendix, I summarize the submissions made by the various participants both on the facts and on policy. I hope in doing so, the reader will be assisted in understanding who argued for what and why. I have also received and reviewed helpful submissions from members of the public, which are in the records of the commission but not summarized in this appendix.

#### **1. Submissions of the Vancouver Police Department and Police Board**

The VPD welcomed this inquiry and the opportunity for recommendations that will improve aspects of the policing and public-health systems. The VPD submitted that the evidence has shown that the system of using police jails to house intoxicated persons deemed to be violent, is not the best way to address the social and public-health challenges that chronic alcoholics present. Nevertheless,

## APPENDIX K

it noted the Jail was functional, and lodged Mr. Paul in a warm, dry environment on hundreds of occasions before his death.

In response to the significant media criticism arising from the Paul matter, the VPD submitted that the most important reality emerging from the evidence is the complete absence of racism, malice or bad faith on the part of police officers, and the complete absence of evidence of an orchestrated “cover-up” of Mr. Paul’s death. The VPD submitted that Mr. Paul’s death was the result of errors in judgement by two police officers.

The VPD addressed in great detail the evidence surrounding Mr. Paul’s life and death, and the department’s response to his death. Mr. Paul interacted with the VPD on an almost daily basis in the mid-1990s. Many officers assisted him and had good interactions with him, but equally, his dealings with police could be strained.

The VPD acknowledged that Frank Paul would likely have lived if Sgt. Sanderson had not turned him away from the Jail that final evening. His was a serious error in judgement, but was not motivated by bad faith. Cst. Instant, too, made a serious error in judgement in deciding to leave Mr. Paul in the alleyway. Their conduct must remain the focus of the examination of the events of December 5, 1998.

The VPD addressed specific points where it had come under criticism for other officers’ conduct that day and night, and defended the decision to let Mr. Paul crawl his way into Jail in the morning; the decision to take Mr. Paul to the Jail in the evening rather than calling an ambulance; the decision not to send Mr. Paul to the Detox Centre; and the practice of dragging him on the floor of the Jail.

Regarding the VPD’s public response, the department pointed out that Mr. Paul’s death was mentioned in media briefings immediately following his death. The VPD submitted that this proves the complete lack of intent to cover up his death. The VPD’s Major Crimes Section investigation was not perfect, and Det. Staunton himself acknowledged deficiencies. The VPD cautioned that his investigation is now being examined with the benefit of hindsight, and with a level of scrutiny commensurate with a much larger budget. A standard of perfection should not be employed. His investigation was reasonably competent. His report contains the

same basic facts as emerged in the public hearings of this inquiry. Although it does not spell out inconsistencies and analyze specific criminal offences, as it might have, the inconsistencies were clear from a review of the report. The investigative steps taken were based on what was known at the time, rather than what is known now with the benefit of hindsight.

The VPD observed that the disciplinary response began with the VPD Internal Investigations Section itself initiating the complaint. The process led to an articulation of the nature of the two officers' errors, and the imposition of punishment on them. Once the range of available sanctions is understood, reasonable people can reach different conclusions. Sgt. Boutin's disciplinary report contains an appropriate analysis of the officers' conduct, and is supported by the evidence led at this public inquiry.

It appears that Frank Paul's family was not initially given accurate information about how he died. It has not been established, however, that the VPD provided inaccurate information. It was acknowledged that both the VPD and Coroners Service should keep better records as to how next of kin are contacted.

The PCC's final conclusions were not commented on by the VPD, but the manner in which the PCC dealt with the Paul file had the unfortunate and unnecessary effect of portraying the VPD in a very inaccurate light, including alleged facts in PCC Ryneveld's call for a public inquiry that were inaccurate and embellished.

The VPD did not take a position on the sufficiency of the civilian oversight mechanisms in the *Police Act*. However, it noted that given the minimal input the OPCC had in the VPD's internal investigation in the Frank Paul case, this case is not necessarily indicative of the manner in which the civilian oversight mechanisms in the *Police Act* were intended to function.

The VPD submitted that I should recommend a change in the manner in which persons who suffer from acute intoxication and chronic alcoholism are dealt with in Vancouver. The drunk tank was submitted to be a relic from a time when chronic alcoholism was seen as a moral issue. The practice of arresting people intoxicated in public, and housing them in the drunk tank, is not the VPD's preferred option. The department has maintained for a long time it should not be in this business. Extreme public intoxication, and chronic alcoholism, should be

dealt with as a public health issue. The VPD asks for a strong recommendation for a properly funded, separate sobering centre, which would accept all those persons currently arrested for being intoxicated in public and unable to care for themselves.

The “wet shelter” proposal should receive serious consideration for Vancouver. The VPD fully supported the involvement of the Aboriginal community in the treatment of chronic alcoholics who are Aboriginal.

**2. Submissions on behalf of the Coroners Service**

The Coroners Service submitted that it is not the organization it was in 1998–99. Back then, inquests were rare, and they did not have the purchase on the public imagination that they do today. Some thought that a coroner working without a jury was a better kind of response to a death, although today people want a jury to consider the facts and deliver its judgement.

The approach taken by the Coroners’ office in the Paul case was properly determined by the responsible coroner. The chief coroner was to set policy and supervise, but the decision to proceed by Judgment of Inquiry was that made by the responsible coroner. It was submitted that from today’s vantage point, one might disagree with her decision. But there was no indication of bad faith and no misconduct involved. She did her best to do the right thing. It was her call to make, and the legislation gives her the authority to make the decision. The legislation also permits the Solicitor General to effectively overrule the coroner if an inquest were felt necessary, but this did not happen.

The present-day Coroners Service *does* address police-related matters by way of inquests. That is what the public wants, and that is what now happens.

The Coroners Service acknowledged failing to contact the Paul family to apprise them of the fact and circumstances of Mr. Paul’s death. As a result, the coroner was unable to take into account the views of the family in determining whether to proceed by way of inquest or by Judgment of Inquiry. The media attention in this case came afterward, and the decision about an inquest in the Paul case may have been different had the Paul family been notified properly.

The Judgment of Inquiry rendered in this case concluded that Mr. Paul was not left in a safe place. The Judgment's recommendations were not aimed at finding fault with the police—that is not its aim—but were directed at changing policies to prevent a recurrence of such a death. They were sound.

Were I to recommend an approach like the Ontario Special Investigations Unit, the Coroners Service agreed it could work very well with such a body.

It is important that this inquiry restore confidence in the public institutions involved in this commission. It may do so by identifying errors and being constructive. It should report on the changes made at the Coroners Service.

### **3. Submissions on behalf of former Police Complaint Commissioner Morrison**

Mr. Morrison was, of course, BC's first Police Complaint Commissioner, from 1998 until resigning in 2002. On his behalf, it was submitted that his response was responsible and appropriate. He acted in consultation with his staff and relied on the facts known and their recommendations on what to do in many instances. He has never shifted blame and has always taken responsibility for the decisions he made.

It was argued before me that Dana Urban's criticism was hypocritical and uninformed. Mr. Urban never made a recommendation to hold a public hearing while he was at the OPCC, but was eventually very critical that none was held. Mr. Morrison now accepts that the initial recommendation (by Bill MacDonald), to hold a public hearing was sound, but that is with the benefit of hindsight. Mr. Morrison may be criticized for the decisions he made, but should not be the subject of any adverse findings by this commission. He exercised his judgement in good faith and acted in the public interest.

### **4. Submissions on behalf of former Police Complaint Commissioner Casson**

Counsel for former Commissioner Casson outlined his role as an interim Acting PCC, which started in July 2002, about two months after Mr. Morrison's resignation, and continued until handing over to Mr. Ryneveld in February, 2003. In this seven-month period, Mr. Casson was concerned about the Paul file and he outlined the steps he took, including efforts to involve Ted Hughes to

prepare an independent report for the Paul family, which ultimately did not take place. Mr. Casson submitted that he had a difficult task in leading an office in a time of transition, and had to walk the line between making decisions and acknowledging his interim status. It was submitted with force that he handled this challenging task appropriately.

**5. Submissions on behalf of Police Complaint Commissioner Ryneveld**

In submissions for the PCC, counsel observed that it was Commissioner Ryneveld's efforts that kept alive the public demand for the creation of this public inquiry.

The OPCC submitted that the VPD should receive criticism for its approach to the OPCC request for identification of the previously unidentified Jail staff and police members seen on the Jail video. The approach taken by the VPD conveyed a false impression of best efforts and ongoing assistance. This serves as a stark example of the VPD's reluctance to accept the concept of full civilian oversight. In addition, the VPD was reckless in suggesting that the OPCC manufactured evidence to support its call for a public inquiry.

It was submitted that since it appeared from Det. Staunton's evidence that the inconsistencies in the evidence had really become apparent only during questioning before me, that the first person to examine the police officers' statements analytically was OPCC investigator Bill MacDonald.

**6. Submissions on behalf of Sgt. Sanderson**

Counsel for Sgt. Sanderson submitted that the easy thing to do would have been to simply admit Frank Paul to the drunk tank. It was the Jail staff who brought to his attention that Mr. Paul did not appear to be intoxicated. Sgt. Sanderson considered the facts himself, and agreed with this view. He concluded that there were no legal grounds to hold Mr. Paul. Sgt. Sanderson's counsel submitted that his sole intention in declining to admit Mr. Paul was to ensure he was not jailed without lawful cause.

It was submitted that Sgt. Sanderson had two reasons for believing Mr. Paul was not intoxicated when he was brought back to the Jail during the evening:

- First, he believed Mr. Paul could not obtain alcohol and get intoxicated in the short time since his earlier release from Jail.
- Second, he concluded Mr. Paul did not look markedly different than his appearance when relatively sober.

While I now have the benefit of the autopsy and other evidence, Sgt. Sanderson did not have such information at the time, and his conclusion was not reckless or unreasonable.

The evidence suggests that even when sober, Mr. Paul was passive and lethargic, rarely spoke, and would sit for extended periods. The likely medical explanation is Wernicke-Korsakoff Syndrome, as described in the evidence of pathologist Dr. John Butt. In addition, Dr. Butt's evidence spoke to the fact that a chronic alcoholic may not show obvious symptoms of impairment even after consuming a great deal of alcohol, because of his acquired tolerance. Sgt. Sanderson did not have the benefit of repeatedly viewing the video of the Jail, nor did he have the post-mortem report or toxicology results.

After he declined to admit Mr. Paul to the Jail, Sgt. Sanderson again chose not to do the easy thing: he did not have Mr. Paul released into the alleyway behind the police station. Instead he learned that Mr. Paul lived at Broadway and Maple, and directed the wagon driver to take him there. If Mr. Paul had been taken to a place out of the elements at Broadway and Maple, he would in all likelihood have slept through the night, just as he had done outdoors hundreds of times before. Evidence established that Mr. Paul habitually slept outside and would not stay put at shelters. He was acclimatized to outdoor living.

It was forcefully argued that Sgt. Sanderson's intentions were entirely commendable. He wished Mr. Paul to be returned to his home neighbourhood. His intentions were not carried out because the instructions he gave to the wagon driver were inadequate. Sgt. Sanderson has admitted his instructions were lacking and this is a significant acknowledgement of responsibility. Cst. Instant's decision to leave Mr. Paul in the alley behind the Detox Centre was a consequence of these instructions, although it was not an inevitable consequence. Cst. English, in fact, countermanded Sgt. Sanderson's direction and advised the wagon driver to leave Mr. Paul in the Detox Centre laneway.

**7. Submissions on behalf of Cst. Instant**

It was acknowledged by Cst. Instant in his evidence and submissions on his behalf that he made wrong choices, and that his decisions played a significant role in Mr. Paul's tragic death.

However, it was observed that the Downtown Eastside is a world of despair and desperation. Policing this area is difficult; officers face pervasive human misery. The training and background of a young officer leaves him ill-prepared for the reality of this environment. Cst. Instant's conduct must be understood within this context, and the fact that he was a very junior officer working within a paramilitary organization.

At the Jail, Cst. Instant was told in clear terms that his understanding—that Mr. Paul was severely intoxicated—was categorically wrong. Sgt. Sanderson said that Mr. Paul could walk and had a disability, and there was no dissent expressed on the fifth floor of the Jail. Cst. Instant repeated this same language in his radio dispatch call upon leaving the Jail.

He expects firm but fair conclusions, based on the evidence. Cst. Instant gave evidence that was generally consistent with, and supported by, other witnesses and documentary evidence, and in particular the audiotape transcripts from the Jail.

Cst. Instant's submission detailed the evidence as it related to his involvement, ultimately asking that his testimony be accepted as honest. It was submitted that there is no basis in the evidence to conclude that his conduct was in any way intentional, callous, malicious or symptomatic of a general indifference for Mr. Paul's life. Reasonable minds can differ as to the choices that might have been made that evening, but reasonable minds will accept that Cst. Instant proceeded with good faith.

**8. Submissions on behalf of the Frank Paul family and First Nations Leadership Council**

Counsel for the family and the FNLC stated that success had already been achieved in that the family and the public now have a record of how Frank Paul

died, and an accounting from all but one institution into their roles in Mr. Paul's death.

It was submitted that this is about Frank Paul, his disabilities, and the way in which he was treated by the dominant society. Whether his Aboriginal status is the governing reason why he died cannot be known on the evidence. What we do know is that it was his Aboriginal status that put him in a place of vulnerability.

The family and the FNLC asked some compelling questions in its closing submissions.

- How could Mr. Paul be released with no shelter, no money, and nowhere to go?
- In so rich a country, how could there be no intervention?

The Paul family graciously pointed out that there were flashes of humanity in the evidence, including the actions of a police officer who gave him a \$2 coin. There were other examples of human compassion transcending the institutional conduct.

Counsel for the family and the FNLC submitted that Dr. Lohrasbe's evidence assists in understanding how such humanity can and should displace the institutional callousness apparent in the evidence.

It was submitted that Sgt. Sanderson was remorseless and morally disengaged. Although he may have fixed on a belief that Mr. Paul was not intoxicated, that was a preposterous conclusion.

Cst. Instant was confused, and one could empathize with his situation. Peggy Clement forgave him for his actions—speaking, she said, for her people and on Frank Paul's behalf—but she also expressed disbelief regarding Cst. Instant's claims of what he actually did. The institutional responses to Mr. Paul's death should be understood as deserving different treatment than individual reactions and conduct. Whereas individual people reacted in the moment, facing various pressures and some immediacy, the institutions had the benefit of an opportunity to reflect. These were decisions made from desks. The VPD set in motion a process that safeguarded the officers; it was not a real criminal investigation and

did not provide a basis for criminal charges. Was this just incompetence, or a systemic mechanism arising for cases where someone dies in police custody? The Coroners Service was quick to conclude that there would be no inquest, and its response failed Frank Paul and the people of BC. The OPCC, like the Coroners Service, made its decision too easily and too early: Mr. Morrison was not going to hold a public hearing. The Ambulance Service witnesses give us hope; their attendants exhibited professionalism and compassion. Other institutions should be renovated in their like.

**9. Submissions on behalf of the Aboriginal Legal Services of Toronto**

The ALST stated that it was important that Frank Paul was an Aboriginal man. The questions surrounding his death have festered for years for the public, and especially for the Aboriginal public. The record of the circumstances of his death would not be complete without identifying what role racism played in his death. Two themes emerge from the evidence. First, there are inadequate resources and services for the homeless population in Vancouver. Second, the province has failed to establish appropriate civilian oversight of the police. It has also failed to ensure that the Coroners Service and OPCC are accountable to the public, and serve the most marginalized members of society.

The ALST proposed four principal recommendations:

- First, intoxication should be decriminalized completely. Mr. Paul was a homeless man who suffered from alcoholism, and was repeatedly brought into police custody for being intoxicated. The effect of BC's laws and the police response was to continue to treat intoxication as a criminal issue. These provincial laws require clarification and they should be amended to restrict the police power to detain intoxicated people. I should also ask whether police are best suited to handling intoxicated individuals, and whether police jails and holding cells are the best place for them to be housed. The lack of guidance to officers on where a person such as Mr. Paul should go—to the Jail, to the Detox Centre, or elsewhere?—was a factor in his death. There should be a stand-alone sobering unit with greater resources. Police should have as little to do as possible with those found intoxicated and unable to care for themselves. There should be a “wet shelter” available to minimize the harm from alcohol consumption, as exemplified by the Annex Shelter in Toronto. The wet shelter should have an Aboriginal-specific component for Aboriginal residents.

- Second, there is a troubled history between Aboriginal people and the police. This is true in BC and nationally. The Commission should not omit the fact that Frank Paul was an Aboriginal person and that his identity may have contributed to how he was mistreated in December of 1998. The VPD should review its use of “caution” entries on the Canadian Police Information Centre (CPIC) computer database. Officers should be trained not just on cultural matters, but on the true history of First Nations peoples. It is necessary to build a new relationship between Aboriginal people and police forces.
- Third, BC’s existing mechanisms for police oversight and accountability failed in the Paul case. Both the VPD investigative and disciplinary responses failed. The province should establish a civilian investigation agency similar to Ontario’s Special Investigations Unit, but should be careful to ensure it is independent, properly resourced, and created with community involvement. The *Police Act* should be amended to grant the OPCC the ability to investigate complaints about the police. Serious matters should not be resolved by way of informal and confidential disciplinary processes.
- Fourth, the province must establish appropriate oversight mechanisms for the Office of the Chief Coroner. A Coroners Service Board should be created, which would be responsible for the oversight and accountability of the Coroners’ office, and would create policy.

#### **10. Submissions on behalf of the BC Civil Liberties Association**

It was submitted that this commission has a unique opportunity to examine the responses of various institutional agencies to disenfranchised people such as Frank Paul, both in life and death. The BCCLA reviewed the evidence of the events surrounding Mr. Paul’s death, and outlined a series of suggested conclusions. These included that Sgt. Sanderson was profoundly wrongheaded to conclude Mr. Paul could not have gotten drunk in the time since his release from Jail. Either Sgt. Sanderson was not truthful, or he committed a profoundly disturbing error in judgment. Sgt. Sanderson knew Frank Paul was homeless and testified he would be able to “bunk down” with someone at Broadway and Maple; in this evidence he was either untruthful or acutely naïve.

It was urged on me that Cst. Instant’s account of the Cobalt Hotel conversation should be preferred to that of Cst. English. Cst. Instant’s account of how he left Mr. Paul in the alley, however, was submitted to be highly suspect. The position

of his body in the alley in their submission justifies the inference that he was left in the same position he was found in, hours later.

The VPD's investigation of the death was woefully defective. It was then relied upon by various other bodies and agencies, and it then polluted each subsequent investigation and review. The disciplinary response led to lax punishments, given the severity of the conduct at issue, and did not involve any element of remediation for the officers. The VPD's next-of-kin notification investigation was likewise inadequate.

The Coroners Service failed to ensure that the facts of Mr. Paul's death were made a matter of public record. In this way it failed to uphold its mandate. An inquest should have been called.

The PCC had the last viable opportunity for a full public airing of the facts surrounding Mr. Paul's death. The case called out for a *Police Act* public hearing to have been held at an early stage. Mr. Morrison's handling of the case was informed by irrelevant considerations.

The BCCLA set out a series of recommendations, many for specific agencies, and two of a general nature. First, as set out in the ALST's presentation, public policy should move to the decriminalization of intoxication. Second, for cases involving death or serious injury, with police involvement, the police should not investigate themselves. Independent civilian oversight should be present at both the investigative and disciplinary stages.

#### **11. Submissions on behalf of the United Native Nations Society**

It was submitted that Frank Paul was one of society's most vulnerable members: a homeless, chronically alcoholic, Aboriginal man. He died prematurely, a victim not of circumstance or lifestyle, but of egregious police misconduct. The "system" then completely failed to respond to his death. To an Aboriginal community reeling from decades of abuse and injustice, the case became a symbol of the uneasy relationship between indigenous peoples and the rest of society. It raises the key question of why the death of an Aboriginal at the hands of police is treated with such indifference by the system. The UNNS wants Aboriginal people

to be treated with more dignity and respect than Frank Paul was shown in his life or death.

The UNNS submitted that members of the VPD failed Frank Paul, his family, and the community, and breached the public trust. Cst. Instant's decision to leave Mr. Paul where he did was inexplicable, indefensible and inhumane. The breach of trust extends to the VPD's investigators and to the department's concept of "neutral" investigations when the force's members were involved in causing someone's death. That "neutral" investigation report was ultimately relied on for police discipline and by the Coroners Service, as well as by Crown Counsel.

Frank Paul's death cannot be divorced from its context, which involves poverty and homelessness, chronic alcoholism, and systemic racism. The fact that Mr. Paul was Aboriginal called out for a heightened level of inquiry into the circumstances of his death. Yet his family was not told the true nature of his death, and the factor of race may have been a key factor in the resistance to a public airing of the circumstances of his death.

The UNNS asked the commission to make a few dozen specific findings on the facts relating to the events of December 5–6, 1998, and the response of agencies to Mr. Paul's death—in particular the inadequate response of the VPD, Coroners Service, and OPCC.

The UNNS proposed a number of recommendations:

- The VPD should emphasize ethical training including the principles advocated in Dr. Lohrasbe's report.
- Governments should address the issue of Aboriginal homelessness in Vancouver.
- There should be addiction treatment programs for Aboriginals, run by Aboriginals.
- A sheltered managed alcohol program for homeless chronic alcoholics should be initiated on a trial basis.
- The public agencies involved in the Paul case should actively seek applications from qualified First Nations people.

## **APPENDIX K**

- Police should not investigate police where there is serious injury or death.
- An independent, civilian-supervised agency should do these investigations.
- Independent prosecutors should review the reports arising from every police-related death.
- The Coroners Service should conduct an independent investigation in all cases where an inquest is mandatory.
- Finally, coroner's inquests should be held within six months of the death.

